34
8/27/02

ORIGINAL

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

VINCENZO MAZZAMUTO, Plaintiff, v. UNUM PROVIDENT CORPORATION; PAUL REVERE LIFE INSURANCE COMPANY; and NEW YORK LIFE INSURANCE COMPANY Defendants	CIVIL ACTION – LAW NO. 1:CV-01-1157 JUDGE KANE JURY TRIAL DEMANDED

PLAINTIFF'S BRIEF CONTRA
DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

I. COUNTERSTATEMENT OF FACTUAL HISTORY

At the outset, Plaintiff challenges Defendants' filing of their Motion for Summary Judgment as being frivolous, not in good faith, contrary to the spirit of motion pleading, and totally unsupported by undisputed facts and law.

On April 23, 2002, Plaintiff's counsel took the deposition of Melissa Mulry, the claims adjuster who handled Mr. Mazzamuto's July 22, 2000, claim for disability benefits that resulted in this lawsuit. Mrs. Mulry's (formerly Magner) deposition with referenced file records in chronological order accompany this brief as **App. Ex. A** (Plaintiff's Appendix Contra Motion for Summary Judgment). The following is an undisputed chronology taken from Defendants' records and Mrs. Mulry's deposition.

1993 – Mr. Mazzamuto purchased his New York Life disability policy. Ex. A to Exhibits in Support of Plaintiff's Motion for Partial Summary Judgment (**PMSJ Ex. A**).

1996/97 – Mr. Mazzamuto made a 1996 disability claim based upon the aggravation of a pre-existing back condition and eventually was paid in 1997 by New York Life (**PMSJ Ex. L**).

7/22/00 – date of disability – first day treated for present claim (**App. Ex. A**, depo Ex. P-1, NYLCL00557).

9/06/00 – Notice of claim (**App. Ex. A**, p. 14).

9/27/00 –Second notice of claim (**App. Ex. A**, p. 16.).

9/29/00 – On New York Life letterhead with an address of 51 Madison Avenue, New York, New York. Mr. Mazzamuto was told that New York Life had

> entered into a reinsurance agreement with Paul Revere Life Insurance Company, a subsidiary of the UnumProvident Corporation, under which they will administer and service, as an agent for New York Life, our individual disability income policies.
>
> * * *
>
> All future correspondence pertaining to your claim should also be sent to this address.

Ex. B to Defendants' Appendix in Support of Motion for Summary Judgment, NYLCL00553 (**DMSJ Ex. B**), emphasis supplied. Also see, similar letter dated 9/28/00 from UNUM, 18 Chestnut Street, Worcester, Massachusetts. Id. at 00554

10/10/00 – Mr. Mazzamuto's claim was assigned to Melissa Mulry (**App. Ex. A**, p. 20).

10/11/00 – Confirmation of receipt of "claims materials" by Paul Revere Life Insurance Company and acknowledgment that Melissa Magner (Mulry) was claims representative (**App. Ex. A**, depo Ex. P-1, NYLCL00552).

10/19/00 – Defendants indicated in two notes that Mr. Mazzamuto's file was missing (**App. Ex. A**, p. 23).

11/1/00 – The Mazzamutos were told that the New York Life Insurance Company disability claim was being transferred to UNUM for administration (**App. Ex. A**, pp. 23, 24, 25)

11/1/00 – Although Paul Revere had acknowledged receipt of "claims materials" on 10/11/00, Melissa Mulry wrote to Mazzamuto stating that she had not as yet received his claim form and an additional application form was being sent to him (almost 2 months since first notice and three weeks since assigned claim).

> Mrs. Mulry's letterhead is UNUM, and the bottom of the page states:
>
> UnumProvident Corporation
> The Paul Revere Life Insurance Company as administrator for New York Life Insurance Company
> 18 Chestnut Street, Worcester, Massachusetts 01608-1528 (emphasis supplied)

There is no explanation as to what this all means, UNUM, UnumProvident, Paul Revere, New York Life. There is no question that Mr. Mazzamuto bought a New York Life disability policy.

11/3/00 – At Defendants' request, Mr. Mazzamuto's doctor Bower sent a report to both:

Paul Revere Life Insurance Company
New York Life Customer Care Center
P. O. Box 15001
Worcester, MA 00615-001

New York Life Insurance Company
51 Madison Avenue
New York, New York 10010

App. Ex. A, depo Exh. P-1. Neither of these addresses is the 18 Chestnut Street address, but they are the addresses given to Mr. Mazzamuto and Dr. Bower

> long history of low back pain and in fact for many years has undergone numerous treatments and physical therapy and MRI in the past did reveal central spinal stenosis which gradually worsened to a maximum at the L3-L4 level and extends from L2 to L5. This has given him periodic problems with lower back discomfort, symptoms of radiculopathy and urinary irritability. Prolonged standing and heavy lifting have aggravated it. He has been seen in physical therapy, treated in a local Pain Clinic with local injections as well as prescription analgesics, non-steroidal anti-inflammatory agents and other atypical chronic pain medications.
>
> Mr. Mazzamuto's condition was complicated this year when he was admitted to the hospital on July 22nd with new onset angina and a small subendocardial myocardial infarction …

> As the patient has attempted to return to work after his recovery from his heart attack, his back has worsened again, also the stress and anxiety which has been provoked because of his recent cardiac problems and manifested themselves with significant anxiety when he is back in a work situation.
>
> * * *
>
> At the present time he is not able to do the work required in running his restaurant because he cannot stand for a prolonged period of time, has difficulty bending, and is restricted from heavy lifting. It is unlikely he will be able to return to work in the foreseeable future.

App. Ex. A, pp. 26-35. Mrs. Mulry testified that she did not receive this letter sent to Paul Revere and New York Life until Mr. Mazzamuto's lawyer sent it to her in a packet of claim materials received on December 15, 2000. **App. Ex. A**, pp. 26-28.

11/15/00, 11/22/00 – Mr. Mazzamuto and Dr. Bower completed two separate applications and physician's statement with different headings and addresses:

New York Life Insurance application, 51 Madison Avenue, New York, NY 10010:

> primary diagnosis 414.01 V45.87, 410.70 secondary diagnosis: 729.1
>
> In your opinion is the patient able to work at this time? No.
>
> (a) The patient was unable to work from 7/22/00 to present
>
> 16. Restrictions and limitations – cannot be in stressful situations, no prolonged standing no lifting

App. Ex. A, pp. 41-44. and depo Exh. P-1.

New York Life Insured's statement of Occupational Duties and Employment completed by Mr. Mazzamuto.

> 10. Cannot perform my duties under the stressful situation. My chest is painful and I am fearful for my life.

Mr. Mazzamuto signed authorization for Defendants to obtain medical records

UNUM application completed by Mr. Mazzamuto and Dr. Bower completed another Attending Physician Statement for UNUM:

Subjective symptoms anxiety, worry, low back pain
Restrictions no prolonged standing, no heaving lifting (2nd to back)
Limitations cannot work in stressful situations
Treatment 7/22/00-10/04/00

App. Ex. A, depo Exh. P-1.

12/15/00 – Mrs. Mulry admits UNUM application and physician's statement plus November 3, 2000, Bower report received by UNUM from Mr. Mazzamuto's attorney. **App. Ex. A**, p. 49. Mr. Mazzamuto had received application forms and other documents from the various different Defendant companies to complete, including a set from Paul Revere, a set from New York, a set from UNUM and at least a second set from New York. **App. Ex. A**, pp. 45, 46. Nevertheless, Mrs. Mulry contended that she did not receive any of these documents until she received a packet of claim materials from Mr. Mazzamuto's attorney on December 15, 2000.

1/04/01 - Mrs. Mulry's first conversation with Mr. Mazzamuto was two days shy of four months from time first notice sent, three months from when Paul Revere acknowledged receipt of claim application and assigned Mrs. Mulry to the file, two and a half months after Defendants lost Mr. Mazzamuto's claim application, two months from when Mrs. Mulry sent Mr. Mazzamuto another set of documents and three weeks since documents received by UNUM. No one knows where the documents sent to New York Life or Paul Revere are. **App. Ex. A**, p. 48.

It was not her normal practice to wait two months before doing something on the file. **App. Ex. A**, pp. 51, 52.

1/08/01 – Action plan prepared – It was not her normal practice to wait so long. **App. Ex. A**, pp. 52, 53, 54

1/09/01 – Mrs. Mulry requested the 1996/1997 claim file. **App. Ex. A**, pp. 55, 56:

Learned "low back pain with a central spinal stenosis back in April the 13th of '96". **App. Ex. A**, pp. 55, 56. Received entire 1996 claim file including all medical records from prior claim. **App. Ex. A**, pp. 56-60. New York Life admitted as to Mr. Mazzamuto's 1996 disability back claim.

> "Since we can't deny on PE [physical exam] or rescind on fraud provision, I am recommending we accept liability for the period of td"

App. Ex. A, p. 60. New York Life paid disability involving Mr. Mazzamuto's central spinal stenosis back problem. In his reports, Dr. Bower said back condition had worsened since 1996. Mrs. Mulry admitted that Mr. Mazzamuto was doing the same kind of work in 2000 as he was in 1996 when he was found to be disabled as a result of his back condition. **App. Ex. A**, p. 62.

1/11/01 – Dr. Bower completed still another report. **App. Ex. A**, p. 80.

1/15/01 – Despite the receipt of Dr. Bower's November 3, 2000, report (**App. Ex. A**, depo Exh. P-1) and numerous other records from Dr. Bower, the entire 1996 file, a medical authorization from Mr. Mazzamuto, Mrs. Mulry wrote to Mr. Mazzamuto stating that medical records were being requested from Dr. Bower and Carlisle Hospital and that such information would be needed before they could determine their liability:

> Your policy states that a claim will be payable when all information that is necessary for us to make a decision is received.

Mr. Mazzamuto again had to complete another occupational description form in full, as well as obtain another progress report from Dr. Bower. **App. Ex. A**, p. 63-70.

1/16/01 –Dr. Bower completed still another physician's report. **App. Ex. A**, p. 77.

1/16/01 – Mrs. Mulry assigned an adjuster to do field report. **App. Ex. A**, p. 120. Not completed for 2-1/2 months until April 4. **App. Ex. A**, pp. 120, 121. box had been checked for 30 days.

1/18/01 – Dr. Bower completed still another progress report. **App. Ex. A**, p. 78. Same information requested and provided over and over by Dr. Bower: "chronic back pain and anxiety". **App. Ex. A**, p. 79

1/18/01 – When asked "how has the disability interfered with the performance of your job" and "please describe sitting, standing and walking requirements and limitations." Mr. Mazzamuto answered:

> My job requires me to stand most of the time. I am always stressed which causes tightness in my chest. Then I have chest pain and shortness of breath. Also by standing my back problem is aggravated. I have been under treatment for back pain since 1996.

App. Ex. A, pp. 83-85, emphasis supplied.

Ignoring what Mr. Mazzamuto told them, without a physical exam and/or any knowledge of what Mr. Mazzamuto had to do in the day-to-day running of his pizza restaurant, UNUM took the position that the general duties of bookkeeping, office work, employee administration noted on Mr. Mazzamuto's application and other forms did not require standing. **App. Ex. A**, p. 94. UNUM relied upon an in-house disability case manager, nurse, and vocational occupational individual all of whom ignored Mr. Mazzamuto's statement that he had to stand most of the time to do his job in denying his claim. **App. Ex. A**, pp. 98-99.

1/22/01 – Defendants sent still another letter to Dr. Bower and Carlisle Hospital for medical records. **App. Ex. A**, pp. 71-75. Mrs. Mulry admitted that these form requests were routinely sent out to doctors on a 30-day interval basis. **App. Ex. A**, p. 76. Mrs. Mulry admitted that Mr. Mazzamuto's back problems in 1996 in and of itself was sufficient to receive disability payments. **App. Ex. A**, p. 82. Defendants, however, after being told by Dr. Bower that Mr. Mazzamuto's back condition had worsened over the four years, refused to pay in 2000 and 2001 because their in-house medical consultants did not feel he was disabled. **App. Ex. A**, p. 82.

3/19/01 –Mr. Mazzamuto's attorney wrote to Defendants as to the reasons why the investigation was taking so long. **App. Ex. A**, pp. 99-100.

In-house physician Dr. Clarke expressed an opinion as to non-disability related to Mr. Mazzamuto's cardiac condition. He did, however, note:

> With respect to his back pain, Mr. Mazzamuto has a long history of lower back pain in association with a degree of spinal stenosis on MRI. In the absence of radiculopathy on physical exam or other studies, this appears to be soft tissue in origin.

App. Ex. A, pp. 101-109, particularly p. 109.

> He indicates that the pain increased with prolonged standing and his physician has restricted him from prolonged standing.

App. Ex. A, p. 110. Mrs. Mulry said that she denied the claim "because I do not feel his occupation required prolonged standing or walking or heavy lifting or bending … because he did mostly managerial and administrative duties, and I feel that those could be performed sitting… I didn't ignore it[what he said that he had to stand all the time or most of the time] but I feel that his – he could perform the duties of his occupation sitting." **App. Ex. A**, p. 111, emphasis supplied.

3/28/01 –Mr. Mazzamuto's attorney called Defendants stating "he [Mr. Mazzamuto] is only one of two cooks and does everything at the restaurant."

4/4/01 – Defendants' adjuster, in his field report noted Mr. Mazzamuto was described as "limping", favoring his right leg, hunched forward, out of breath, majority of weight was on left side, pleasant, cooperative, answered questions fully, father had a stroke and three heart attacks and afraid he might have one and die "While working at the business, he gets nervous and sometimes loses his temper." "He's afraid if that happens he may have another heart attack." "Secondly, he stated that when he was put in an ambulance when he had his heart attack and was transported to the hospital, he re-injured his back." "Claims that his back is as bad now as it was in 1996." They paid in 1996 but won't pay now." **App. Ex. A**, pp. 123-128, emphasis supplied.

> Q. Says he has numbness in his right leg. … can't bend … when he sleeps, he sleeps on his stomach with pillows under his stomach, ankle, and head … as far as sitting, standing or walking, he stated he can only do these activities for about 20 or 30 minutes before changing positions….

App. Ex. A, p. 140. Mrs. Mulry went on to say that she did not believe that medical records support that his back was worse than 1996. May have been the same. On the review of restrictions and limitations that Dr. Bower placed on insured, Mrs. Mulry did not feel that the

restrictions and limitations would prevent him from performing the duties of his occupation. **App. Ex. A**, p. 129. She felt that the restrictions and limitations in 1996 were the same as 2000. She admitted the job was the same in 1996 as 2000. **App. Ex. A**, p. 129. Mrs. Mulry continued to rely on Dr. Clarke who stated that there did not appear to be any significant structural change in his condition associated with the recent exacerbation "so my understanding of that statement is there doesn't appear to have been a change from 1996 to [2000]" **App. Ex. A**, p. 131.

Mrs. Mulry stated that the basis for their denial of Mr. Mazzamuto's claim was Dr. Clarke's report:

> I believe that again based on the duties of his occupation, and based on the restrictions and limitations that Dr. Bower placed on Mr. Mazzamuto, I believe that he could perform the duties of his occupation perhaps with accommodations, he could sit performing the duties.
>
> * * *
>
> He [Dr. Clarke] doesn't indicate who says that. He just says "the degree to which he's required to stand or walk for prolonged uninterrupted periods of time over 15 to 20 minutes at a time is not clear. I believe that the insured may have stated this, that after 15 to 20 minutes he experiences pain, but I don't believe a physician said that.
>
> * * *
>
> Again, I don't believe that his job required him to stand most of the time.

App. Ex. A, pp. 134-135, emphasis supplied.

* * *

> He may have stood most of the time but, again, I believe he could perform those duties sitting. I don't see why he couldn't.

App. Ex. A, p. 136, emphasis supplied. Mrs. Mulry admitted that she did not know where Mr. Mazzamuto worked and what his duties were or that he stood behind a tall counter and that he couldn't sit behind a tall counter and function effectively or that he took money at the cash register. **App. Ex. A**, pp. 136, 137. "... Again, I believe with accommodations he could

perform the duties of his occupation." **App. Ex. A**, p. 137. "I don't … first of all, I don't believe he took money. I don't recall that being a duty of his occupation but I believe that he could … he could sit with accommodation. He wouldn't have to sit behind a counter." **App. Ex. A**, pp. 137, 138.

> So you turned down this man, and he has not been able to collect any disability insurance, for which he paid, for almost two years without you even knowing where he had to stand, is that right?
>
> * * *
>
> A. Correct.

App. Ex. A, p. 138, emphasis supplied.

> Did you ever send him to some doctor to have him examined?
>
> A. No, we did not.

App. Ex. A, p. 140, emphasis supplied.

> So you denied his claim without even having him examined, is that right?
>
> A. Correct.

App. Ex. A, p. 140, emphasis supplied.

4/20/01 – Mrs. Mulry sent letter denying Mr. Mazzamuto's disability claim. **DMSJ Ex. F.**

5/8/01 – Mr. Angino wrote a letter to Mrs. Mulry summarizing Mr. Mazzamuto's claim and suggesting that Defendants would be guilty of bad faith if they did not pay the claim on the basis of the existing record.

3-ring binder of records

Italian immigrant

Family restaurant business

1993 disability policy

April 20, 2002, letter – not paying because she believes he can do job

Job requires working long hours, standing on feet, greeting guests, circulate, substitute for others, lift and bend. Doctors told him he cannot continue working. If case can be settled promptly through exchange of correspondence, little by way of fee and expenses. If required to start suit, bad faith claim. **DMSJ Ex. B**, NYLCL00365.

5/23/01 – Without any investigatory action responsive to Plaintiff's counsel's 5/8/01 letter, , Mrs. Mulry stated that Defendants were sticking with their April 20, 2001, position. **DMSJ Ex. B**, NYCL00362

6/26/01 – Suit filed

7/12/01 - Dr. Schneider submitted report for Social Security Administration. **PMSJ Ex. F.**

4/16/02 – Defendants took Dr. Bower's deposition. **DMSJ Ex. G**.

6/13/02 - Plaintiff's filed first expert report. **DMSJ Ex. H**.

6/14/02 - New York Life agreed Mr. Mazzamuto disabled as to his life insurance premium. **PMSJ Ex. H**.

6/27/02 - Defendant Dr. Steinman expert report – never examined patient – opinion from records can work from orthopedic standpoint with accommodations. **DMSJ Ex. L**.

6/28/02 - Defendant Dr. Hostetter expert report – never examined patient – cannot express opinion. **DMSJ Ex. K**.

7/11/02 - Plaintiff's filed second expert report. **DMSJ Ex. H**.

7/25/02 - Mr. Mazzamuto found totally disabled by Social Security Administration

8/9/02 – Defendants filed Motion for Summary Judgment and Motion in Limine.

8/15/02 – New York Life re-confirmed that Mr. Mazzamuto is totally disabled and need not pay life insurance premiums. **App Ex. B**.

8/22/02 – Plaintiff's counsel received from expert Rose transmitting article from former UNUM employee: "Doctor's Suit Asserts UnumProvident Had Policy Of Denying Claims:"

> The suit, filed June 28, was brought by Patrick Fergal McSharry, a doctor who once worked as a medical director for UnumProvident in Chattanooga., Tenn. He claims the company employed doctors "to provide language and conclusions supporting denial of claims."

App. Ex. C.

IV. ARGUMENT

In response to Plaintiff's request, Defendants supplied UNUM's claim manual. Relevant sections are attached as **App. Ex. D**.

> It is designed and intended to be a reference guide to claims professionals and others in the Customer Care Center on the handling of claims …
>
> 1) Every claim … is different and must be decided on its own unique … facts …
>
> 2) In the handling of each claim, the Customer Care Center will strive to comply with all applicable laws. In support of that goal, this Manual contains overviews of a variety of legal rules and guidelines … (emphasis supplied)
>
> * * *
>
> **States: Pennsylvania**
>
> Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Pa.Adm.Code 146.1 et seq.; Pa.St.Ann. 1171.5(10).
> 1. Adopted law similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.
> 2. Specific Time Restrictions:
> Acknowledge receipt of notification of claim: 10 days
> Provide necessary claim forms: 10 days
> Respond to communications from claimant: 10 days
> Begin investigation of claim: None
> To complete investigation of claim: 30 days
> Notify claimant that more time is needed to review claim: 15 days after receipt of proofs of loss
> Send follow-up letters that investigation is incomplete: 30 days from the date of the initial notification requesting more time, and then 45 days thereafter.
> Accept or deny claim after receipt of proofs of loss: 15 days (emphasis supplied)

The Manual goes into great detail as to "Guidelines for Evaluating an Occupation:"

In determining what an insured's own occupation should be, consider the following:

- What were the material and substantial duties the claimant performed?
- How did the insured spend his time?
- From what activities was his income generated?

The insured's "own occupation" or "regular occupation" is the occupation which the insured was engaged in at the time of the disabling injury or sickness.

The following sources can be used to establish the insured's occupation:

- appointment books, calendars, schedules (including surgical schedules), or other evidence of how the insured spent his time prior to disability;
- billings;
- job description, personnel file, etc., if the insured is an employee of a firm that generates such materials;
- evidence of earned income W-2s, tax returns, etc.;
- authored works such as reports, memoranda, publications, etc.;
- timesheets; and
- vocational resources such as Dictionary of Occupational Titles, Occupational Outlook Handbook etc. (emphasis supplied)

* * *

Job vs. Occupation Assessment

The essence of the job vs. occupation or own occupation assessment is a comparison of the specific duties performed prior to disability with the occupational duties as generally performed in the national economy.

The term "occupation" is often interpreted to be the same as a "job." This interpretation is incorrect as a job differs from an occupation in that a job is a set of specific duties performed at a particular employer whereas an occupation is a broader description of the type of work as is generally performed in the national economy. (emphasis supplied)

The Manual discusses "Attending Physician Statement" and "Claimant Statement" and suggests that they should be received at least quarterly on the "Rationale" that circumstances may be changing. Otherwise, 12-36 month intervals.

The Manual provides assistance in evaluating a claim in the following order:

- Contractual Provisions
- Claimant Activities
- Occupational Duties
- Financial Information

- Medical Information

> As illness or injury is at the foundation of every claim, medical information is fundamental to an understanding of a claimant's restrictions and limitations, opportunity for recovery, and capacity for return to work.
>
> * * *
>
> During the claims evaluation process, medical information should be assessed for its credibility and relevance. There are a number of avenues, beyond the treating healthcare provider, available for obtaining an assessment of the medical information and/or the claimant's restrictions and limitations including:
> - Independent Medical Examination (IME)
> - Functional Capacity Evaluation (FCE)
> - Internal Medical Personnel
>
> "File Documentation" is emphasized.

Although Defendants' Manual directs the professional to the contractual provisions, claimant activities, occupational duties, financial information and medical information and suggests numerous sources for determining an insured's job, specific duties, claimant activities, occupational duties, financial information, and medical information from "the treating health care provider," as well as IMEs and FCEs, Defendants' Motion for Summary Judgment and Statement of Facts ignores all of these sources and relies on general occupational descriptions provided by the New York Life agent who sold the policy and some general information supplied by Mr. Mazzamuto. Defendants' agent and experts candidly admit no knowledge whatsoever as to what Mr. Mazzamuto actually did at the time he became disabled.

The bottom line is that Defendants' Motion for Summary Judgment does not begin to approach the standard of proof required for such a motion. It is a waste of valuable court and counsel time to have to respond and/or adjudicate such issues under the well-established summary judgment standard.

> Summary judgment should be granted when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact, and ... the moving party is entitled to a judgment as a matter of law." Fed.R.Civ.P. 56(c). A fact is

> "material" if proof of its existence or non-existence might affect the outcome of the suit under the applicable law." *Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248, 91 L.Ed. 2d 202, 106 S. Ct. 2505 (1986).* A dispute is "genuine" if the evidence "is such that a reasonable jury could return a verdict for the non-moving party." Id.

Krisa v. The Equitable Life Assurance Society, 113 F. Supp.2d 694, 700 (M.D. Pa. 2000) (emphasis supplied).

Plaintiff does not dispute that it is Plaintiff's burden to prove that he is "disabled" as defined in the policy and to prove that Defendant breached its obligation to pay benefits" and that Plaintiff has the burden of proof under an "occupational" disability policy to prove that he is disabled within the occupational definition of the policy. See, Provident Life and Paul Revere cases referenced on pages 16 and 17 of Defendants' Brief.

Plaintiff has filed a Motion for Partial Summary Judgment where the uncontested facts and law clearly show that Plaintiff is totally disabled in terms of the New York Life disability policy and was so found by New York Life under a similar, if not more restrictive definition of total disability under Mr. Mazzamuto's life insurance policy, as well as under the very strict standard required for Social Security disability. Following Defendant's own Manual "Guidelines for Evaluating an Occupation," it is clear that Defendants did not do what the Manual requires in "Establishing Occupation" and "Job vs. Occupation Assessment."

Plaintiff refers the Court to Judge Vanaskie's opinion in Krisa with respect to his holdings on plaintiff's breach of contract claims, as well as Krisa's bad faith claim. Also see, Simon v. UnumProvident Corp., 2002 U.S. Dist. LEXIS 9331 (E.D. Pa. May 23, 2002).

Although Judge Vanaskie granted Equitable Life's motion for partial summary judgment as to Krisa's bad faith claim, his decision was based upon the particular factual circumstances of the case, and he did not express any opinion "on whether Krisa is entitled to a jury trial on his

post-litigation bad faith claims." Krisa, 113 F.Supp.2d at 705. See, Simon, supra and Polselli v. Nationwide Mut. Fire Ins. Co., 23 F.3d 747 (3d Cir. 1994).

This diversity case is controlled by Pennsylvania substantive law. The principal Supreme Court case dealing with total disability is Cobosco v. Life Assurance Co. of Pennsylvania, 419 Pa. 158, 213 A.2d 369 (1965). The Pennsylvania Supreme Court agrees that it is an insured's obligation under an occupational disability policy to prove disability with respect to her particular occupation "hardware merchant."

> In our opinion, where, as here, the question of "total disability" must be decided in the context of the ability of the insured to perform the acts or duties necessary to the operation of a business owned by him, the cases hold that the insured must prove that the personal efforts that he himself is capable of making in the operation of the business are insubstantial and unimportant, by reason of their low quality or quantity, in relation to the character and amount of work required to carry on the business. (citing numerous cases)
>
> * * *
>
> The insurance company has argued that we should consider the substantiality and importance of Mrs. Cobosco's efforts only in relation to the duties of supervising and managing the store rather than in relation to all the duties involved in the operation of the store. The argument is based upon the fact that, in her insurance application, Mrs. Cobosco noted her "duties" as "manager supervisory". Even if we were to accept the insurance company's argument, the jury might have reasonably concluded that the limited amount of time that she was able to spend in the store prevented Mrs. Cobosco from making a substantial and important contribution to the fulfillment of the duties of a manager and supervisor. Moreover, we do not agree with the insurance company's argument. Mrs. Cobosco was insured against her inability to "perform duties of any gainful occupation for which [she] may be reasonably fitted by reason of training, experience and accomplishment," which, under the facts of this case, means inability to perform duties of operating her hardware store. The occupation which Mrs. Cobosco noted in her insurance application was that of a "hardware merchant". This occupation reasonably implies the whole range of duties included in the operation of the hardware store and not just "manager supervisory" duties. (citing authority) Thus, both her occupation, in fact, and that stated in her policy includes more than manager supervisory duties.

Cobosco, 419 Pa. at 166, 169-170. Also see, Brosnan v. Provident Life and Accident Ins. Co., 31 F. Supp.2d 460 (E.D. Pa. 1998). The Eastern District held that Dr. Brosnan's occupation was

"anesthesiologist" and not medical doctor and, consequently, he was entitled to total disability benefits even if he could and was regularly employed following his disability as a "doctor."

The instant case involves the Defendants' policy definition of "job" which Defendants' Manual admits is even more restrictive than "occupation." It is not a question of what presidents and owners or general managers do generally. What specifically did Mr. Mazzamuto do as the owner/operator of a pizza restaurant? It is not a question of general type of activities of administration, bookkeeping or supervision. What were Mr. Mazzamuto's specific daily activities? Did he stand or sit, bend or lift, how much, how often? To answer these questions, one needs to conduct an investigation, to go to the site, to talk to Mr. and Mrs. Mazzamuto, his employees and customers, to take pictures, obtain statements, see what Mr. Mazzamuto's replacement does. What do other owners of small pizza restaurants do, etc.?

This case involves delay in responding to communications, excessive response time in engaging an investigator and conducting an investigation, inadequacy of investigation, failure to find out what Mr. Mazzamuto actually did at his job, relying on general statements in writing rather than specific statements given, failing to engage a doctor to examine Mr. Mazzamuto, ignoring Mr. Mazzamuto's statement that he has to stand most of the time, denying Mr. Mazzamuto's claim because Defendants' adjuster felt that he could work in a sitting position, ignoring the definition of "disability" or "job" in the policy, relying upon in-house "experts," ignoring the facts, ignoring the opinions of Dr. Bower, Schneider, the Carlisle Hospital records, New York's denial of disability under its disability policy in the face of the finding of total disability under New York's life policy on two separate occasions, and the finding of total disability by the Social Security Administration.

On the issue of bad faith, there is certainly a factual issue as to whether an insurance company is guilty of bad faith under the factual circumstances of this case. See, Polselli v. Nationwide Mut. Fire Ins. Co., 23 F.3d 747, 752 (3d Cir. 1994):

> On the other hand, the court should consider whether Nationwide's delay in responding to communications from Polselli, its poor response time in engaging an investigator and in conducting the investigation and its handling of the settlement negotiations suggest that Nationwide did not "accord the interest of its insured the same faithful consideration it gives its own interest." citing *Cowden v. Aetna Cas. & Surety Co.*, 389 Pa. 459, 134 A.2d 223, 229 (1957).

As to the use of experts in bad faith cases, they have been used by both sides in virtually all cases. The Third Circuit's decision in Dinner v. United Services Automobile Ass'n Cas. Ins. Co., 2002 U.S. App. LEXIS 3408; 29 Fed. Appx. 823 (3d Cir. 2002), upheld the trial court's decision to admit or exclude certain expert testimony but not all expert testimony under the abuse of discretion standard noting that every violation of the Unfair Insurance Practices Act is not *per se* a violation of the bad faith standard, and acknowledging that the trial court did allow plaintiff's expert to testify about a number of instances of perceived misconduct based on her knowledge of the case and the insurance industry.

Plaintiff's counsel was trial and appellate counsel in Klinger v. State Farm Mut. Auto Ins. Co., 115 F.3d 230-233 (3d Cir. 1997) and also Syracuse Exploration Company v. Northbrook Property & Cas. Ins. Co., 216 F.3d 1077 (3d Cir. 2000).

In both Klinger and Syracuse, experts were used. As a point of fact, in Syracuse, defendant, over plaintiff's counsel's objection, was permitted to call a lawyer to testify, who was an author of a bad faith textbook. He was permitted to testify over our Plaintiff's counsel's objection that he was an authority on "bad faith," that lawyers and judges rely upon his book, that his book is cited by judges, and in his opinion the insurance company in the Syracuse case was not guilty of bad faith. Judge Caldwell ruled this was proper. **App. Ex. E.** The Third Circuit affirmed. **App. Ex. F.** The U.S. Supreme Court refused to grant certiorari. **App. Ex. G.**

Plaintiff's counsel has also been successful in entering evidence and submitting points for charge referencing the Unfair Insurance Practices Act, *e.g.* points in Syracuse. **App Ex. H**. Also see, Romano v. Nationwide Mut. Fire Ins. Co., 435 Pa. Super. 545, 646 A.2d 1228 (1994); O'Donnell v. Allstate Ins. Co., 1999 Pa. Super. 161, 734 A.2d 901 (1999).

Bad faith actions are not limited to bad faith in denying claims but also may extend to bad faith insurer's investigatory practices, as well as bad faith conduct of an insured during the pendency of litigation. O'Donnell v. Allstate Ins. Co., supra, Romano v. Nationwide, supra, Certainteed Corp. v. Federal Ins. Co., 913 F. Supp. 351, 360-61 (E.D. Pa. 1995); McFarland v. United States Fidelity & Guarantee Co., 818 F. Supp. 108, 110-11 (E.D. Pa. 1993); Rottmund v. Continental Ins. Co., 813 F. Supp. 1104, 1109 (E.D. Pa. 199_). Also see, Polselli, supra and Krisa, supra.

In addition to the references in Defendants' Manual, the following are relevant Unfair Insurance Practices Act provisions and relevant regulations which Defendants have violated:

40 P.S. §1171.5

(i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

(ii) Failing to acknowledge and/or fail to act promptly upon written or oral communications with respect to claims arising under insurance policies.

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

* * *

(vi) Failing to attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.

(vii) Compelling persons to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts due and ultimately recovered in actions brought by such persons.

40 P.S. §1171.5. Defendants are guilty of violating all of the above subsections.

Unfair Insurance Practices Act - Regulations, Title 31, §146.1, et seq.

§146.5 Failure to acknowledge pertinent communications.

(a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

§146.6 Standards for prompt investigation of claims

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

§146.7 Standards for prompt, fair and equitable settlements applicable to insurers.

(a) Acceptance or denial of a claim shall comply with the following:

(1) Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to

the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

* * *

(b) If a claim is denied for reasons other than those described in subsection (a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(c) The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination:

(1) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected.

(2) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority for suspecting that the first-party claimant has fraudulently caused or contributed to the loss by arson or other illegal activity, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

Also see, The Birth Center v. The St. Paul Companies, Inc., 1999 Pa. super. 49 727 A.2d 1144 (1999) for additional discussion of "bad faith" law in Pennsylvania. Also see, Simon v. UnumProvident Corp., 2002 U.S. Dist. LEXIS 9331 (E.D. Pa. May 23, 2002) for background information as to possible joint responsibility of UNUM, Paul Revere, and New York Life and Defendants' possible "bad faith" of requiring duplicate and triplicate and weekly, bi-weekly and monthly filings by Plaintiff and his doctors.

At this point, Plaintiff's counsel does not know the position Defendants are taking as to sole or joint responsibility of the various Defendants in administering, deciding, and paying insureds under New York Life disability policies. Mrs. Mulry testified in her deposition that she herself does not know the legal ramifications of the se various companies, *i.e.,* UNUM,

UnumProvident, Paul Revere, New York Life. Even Defendants' filing of their Motion for Summary Judgment and Motion in Limine without any legal or factual basis whatsoever can be found by a jury to be acts of bad faith. Plaintiffs will be filing a Motion to Extend the Deadline for Filing Expert Reports to add Dr. Patrick Fergal McSharry on the basis of his lawsuit against UnumProvident. **App. Ex. C**.

Respectfully submitted,

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Attorney for Plaintiff

Date: 8/26/02

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

VINCENZO MAZZAMUTO,
Plaintiff

VS. C.A. NO. 1:CV-01-1157

UNUM PROVIDENT CORPORATION; PAUL REVERE LIFE INSURANCE COMPANY; and NEW YORK LIFE INSURANCE COMPANY,
Defendants

DEPOSITION of MELISSA MULRY taken at the request of the plaintiff pursuant to Rule 30 of the Federal Rules of Civil Procedure before Dianne G. Rutan, a notary public in and for the Commonwealth of Massachusetts, on April 23, 2002, commencing at 9:00 A.M. at 41 Elm Street, Worcester, Massachusetts.

A P P E A R A N C E S :

FOR THE PLAINTIFF:

RICHARD G. ANGINO, ESQ.
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FOR THE DEFENDANTS:

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STEVENS & LEE
111 North Sixth Street
P.O. Box 679
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- and -

EDWARD T. CORRIGAN, ESQ.
UNUMPROVIDENT
18 Chestnut Street
Worcester, Massachusetts 01608

I N D E X

DEPONENT: MELISSA MULRY

EXHIBITS

(Plaintiff's Exhibit No. 1 premarked.)

MELISSA MULRY, SWORN

EXAMINATION BY MR. ANGINO:

Q. I'm going to be taking this deposition for both discovery and potential use at trial. So if you have any objections to any of the questions --

MR. HENEFER: You don't want to have the usual stipulations then?

MR. ANGINO: No, no.

MR. HENEFER: Okay.

Q. What is your full name?

A. Melissa Ann Mulry.

Q. What is your home address?

A. I'll give my business address.

Q. That's fine.

A. 18 Chestnut Street, Worcester, Massachusetts.

Q. And how long have you worked for the particular company that you work for?

A. In September, it will be four years.

Q. What is the name of the company that

Page 5

you work for?
A. UNUMProvident Corporation.
Q. Where had you worked before this?
A. I was actually right out of college. I graduated from college in 1998. Prior to that, when I was in college I worked for the Devereux Foundation.
Q. What college did you go to?
A. Anna Maria College, Paxton, Massachusetts.
Q. And when you came to work for UNUM, in what capacity did you come?
A. What do you mean "what capacity"?
Q. What were you hired to do?
A. Claim representative. I was actually an assistant claim representative.
Q. Did you have to go to any particular school or training?
A. I had three months of training before I was released to my department.
Q. Would that be on-the-job training?
A. I had contract training -- I'm not exactly sure -- but I had contract training and some on-the-job training. But most of it was --

Page 6

actually I had three months of training prior to even any on-the-job training.
Q. And were there certain books or written material provided to you during this course of training?
A. Yes.
MR. ANGINO: Off the record.
(Discussion off the record.)
Q. Back on the record. With regard to working as a claims representative, were there certain procedures and protocols involved?
A. Yes.
Q. And are those in writing?
A. I'm not sure.
MR. ANGINO: Off the record.
(Discussion off the record.)
Q. Back on the record. New claim, what is the procedure that you follow?
A. Handling a new claim? We would -- first I would review all of the benefit information, the contracts and I would review the claim form in its entirety and I would contact the insured by telephone, to do a telephone interview.

Page 7

Q. Let's assume that a claimant, an insured, goes to his agent and reports the claim. And that report comes to you. What's the first step?
A. The report comes from the agent?
Q. Yes.
MR. HENEFER: Do you mean like a verbal report, or an actual claim form?
MR. ANGINO: A verbal report.
MR. HENEFER: Verbal report. Okay.
A. I would then speak with the agent and ask that he submits the necessary claim forms to proceed.
Q. Let's take the other alternative, the claimant or the insured calls, what do you do?
A. If I don't have the claim form, again I would ask for the claim forms to review.
Q. And when we talk about a claim form, is that an application for benefits?
A. Yes.
Q. So that the first step when you receive an oral report, whether it come from an agent or whether it come from the insured, or even if it were a written notice, your first

Page 8

would be to send a claim form?
A. Exactly. Yes.
Q. When you're dealing with individuals from other states, did you have any training in terms of like unfair insurance practices law in a state such as Pennsylvania?
A. Not that I recall.
Q. How about in terms of Massachusetts?
A. I don't recall.
Q. So that at the present time, are you aware that there are time lines in which things have to be done?
A. I am aware of time lines, not specific.
Q. What are the time lines of which you are aware?
A. I am aware that certain states there are time lines. I don't know any specific Pennsylvania. I do know that we were instructed to handle mail within seven to ten business days.
Q. So mail within seven to ten business days?
A. Mm-hmm.

Page 9

Q. How about telephone calls, responding to?
A. At the time there were no specific guidelines that I can recall.
Q. So that if you get a telephone call, you're not aware of any specific time line to respond to that telephone call?
A. Correct.
Q. You get a letter, you're supposed to respond within seven to ten days?
A. (Witness nods.)
Q. Is there a time period in which you need to make a decision of which you're aware?
A. Not that I know off the top of my head.
Q. Is there any time period when you get a notice of a claim that you need to send out the application or the claim form?
A. I'm not sure. I don't -- our intake department handles that. So I don't actually send out the claim forms myself.
Q. Your department would be called what?
A. The claims department.
Q. So you're the claims department.

Page 10

A. Mm-hmm.
Q. And you say there's an intake department?
A. Yes.
Q. And the intake department, what do they do?
A. They actually set up the claim. They would set it up on the computer and they would receive the telephone call, and then they would actually send out the claim forms.
Q. So, really, you get involved when the case is assigned to you?
A. Correct.
Q. Intake handles it before you get involved?
A. Yes.
Q. All right. So that once you get involved, there's already written claim forms; is that right?
A. Typically. In this case, there wasn't, but typically speaking, that's how it should work.
Q. And since you're saying what happened in this particular case, in contra-distinction

Page 11

from other cases, you've obviously reviewed the file?
A. Correct.
Q. And you've gone over the file with your attorney?
A. Yes.
Q. I'm not going to get into specifically what. But you've discussed the case with your attorney; right?
A. Yes.
Q. What I've done, I've marked as Plaintiff Exhibit No. 1 a packet of papers which are in front of you.
A. Okay.
Q. And there's another packet for your attorney. And what I'm going to do is I'm going to proceed chronologically. I've set this packet of papers up in a chronological fashion, as best as I could.
A. Okay.
Q. And what I'm going to ask you are questions dealing with these papers.
A. Okay.
Q. All right. Each of these papers

Page 12

carried a Bate stamp number and I will occasionally refer to the Bate stamp number. I'm going to ask you try to keep them in the order in which they are set up, because when this case comes to trial this is the order in which the deposition is being taken. Do you understand?
A. I understand.
MR. HENEFER: The first page, Richard, I think the Bate's number might have been cut off. I can locate that for you if you want.
MR. ANGINO: At the appropriate time, we can do that.
Q. And what I'm going to ask you is, you have occasion to use the word "uh-huh." I'm going to ask for yes or no.
A. Okay.
Q. It will be easier when we get to court. Okay is even fine. But uh-huh is a difficult thing for the jury to understand. Okay?
A. Okay.
Q. The first paper is one carrying an

attorney's name, it's Peter J. Russo. Do you see that?
A. Yes.
Q. And although the date of the particular letter is March 26, 2001, the reason it is first is it referenced that in July you were provided verbal notice of a claim. Do you see that? Second paragraph, mid part of the second paragraph.
A. Mm-hmm.
Q. There you go again.
A. I'm sorry. Yes. I see that.
Q. Are you aware that there was a verbal notice in July of the year 2000 with respect to a claim by Mr. Mazzamuto?
A. Yes.
Q. And can you tell us what form that July notice took?
A. What do you mean?
Q. It's verbal. Was it a telephone call?
A. I believe it was a telephone call.
Q. To whom?
A. I believe to our intake department.

Q. So in July, there's a telephone call to your intake department. What happened to that July telephone call?
A. I'm not sure. I would have to look through the file, but I believe I actually, it's the second page right here.
Q. Well, that particular second page is carrying a date as I see it of September. Right-hand, down at the bottom, 9/6/2000. Do you see that?
A. Yes.
Q. What about the July call?
A. I would have to look through the file. I may have been confused with this date here.
MR. HENEFER: The witness is pointing to the date that says "first date treated."
Q. Yes, there is a date of disability of 7/22. Do you see that?
A. Yes.
Q. But this particular document, which is carrying a Bate stamp of 557 is showing a 9/6/2000 date recorded by a Diann Jarvis. Do you see that?

A. Yes.
Q. So that, if there was a verbal notice in July, do you know where the document is for that verbal notice?
A. I would not -- if it wasn't in the claim file, then I would not have known about the July. If it existed, I don't know where it would have been. But their normal procedure is to document it on this form.
Q. And what we are looking at is an initial setup form for a new claimant; is that right?
A. Yes.
Q. So there's no question in your mind that the claimant contacted your intake department at least as early as September the 6th. Is that right?
A. That's right.
Q. And the normal procedure would be once that contact is made, written documents, and application should have been sent to the claimant. Is that right?
A. Correct.
Q. Now, I've gone through the file, and

I don't see written documents having been sent to the claimant, say, within a week or ten days after September 6, 2000. Is that accurate?
A. I'm not sure. I'd have to look through the claim file.
Q. Well, do you have any knowledge that there were written documents sent?
A. I don't.
MR. HENEFER: Sent when?
Q. Sent within seven to ten days of the date of 9/6/2000?
A. I'm not sure when they sent the forms.
Q. Apparently, there's another document of an initial setup form almost identical except the one doesn't have that there was a prior claim, the second form, which carries the Bate stamp of 556, says there was a prior claim in 1996. Is that accurate?
A. Yes, that's accurate.
Q. This time a Kimberly Barbee is getting the information. Is that right?
A. Yes.
Q. So that, there were to be documents

sent after this 9/6 call, there should have been documents sent after the 9/27 call, is that right? Normal procedure.

A. Normal procedure, yes.

Q. The next thing we see in this series of documents as I've been able to put them together --

A. Mm-hmm.

Q. You said uh-huh.

A. I'm sorry.

Q. That's all right. I'll have to keep reminding you of that.

A. It's a habit. I'm sorry.

Q. That's all right. The next document I'm looking at is carrying a date of October 11, 2000 with a Bate stamp of 552. Do you see that?

A. Yes, I do.

Q. While we're still in the opening stages of this deposition, as I said, I've tried to set them up in chronological fashion. And you said I can't be certain without looking at the documents. If after this deposition is completed, and if after you have a chance to look at the documents, you find things that in

any way contradict what we're talking about here, would you --

MR. HENEFER: She'll confer with counsel.

MR. ANGINO: That's what I was going to say. Confer with counsel.

Q. We want you to be accurate in terms of what you said.

A. Okay.

MR. HENEFER: I'm noticing as we go through this, Richard, that there are some documents that are missing from your compilation. Just to let you know. For example, there are some letters that went out at the end of September.

MR. ANGINO: I couldn't find them. That's why I'm saying, if there were letters that went out, then I don't have them. Because I've gone through this file very meticulously to try to put together, you know, a chronological --

MR. HENEFER: We should probably go off the record.

(Discussion off the record.)

MR. ANGINO: Let's continue.

MR. HENEFER: Still off the record.

(Discussion off the record.)

MR. ANGINO: Back on the record.

Q. I've been given by counsel a letter of September 29, 2000, which is addressed to Mazzamuto, it's coming from disability income claims. And it states that -- "It's our understanding that you wish to present a claim under your individual disability policy."

Is that correct?

A. Yes.

MR. HENEFER: Just so the record's clear Bates label 553.

Q. Would this be the intake's form letter in response to a telephone call?

A. Yes.

Q. The next letter that I have is October the 11th, and you probably have something before that, that somehow got mixed up in my form.

MR. ANGINO: But, may I borrow this one for a second?

MR. HENEFER: Yes.

Q. There is a particular document carrying the Bate stamp of 563. And it appears to be something that is used in order to assign a claim. Is that accurate?

A. Correct.

Q. Because it says off to the right, assigned 10/10/2000. Is that right?

A. Yes.

Q. So that the very next day after a 10/10 assignment is indicated, there is a 10/11, or October 11th letter to Mr. Mazzamuto saying that you have been assigned the claim. Is that right?

A. That's right.

Q. Now, you said normally by the time you get assigned the claim, a disability form has already been -- an application has been filled out. Is that right?

A. Normally.

Q. But in this particular case, it hadn't?

A. It hadn't. Correct.

Q. So, when it's assigned to you and there is no disability claim filled, or

application filled, what's your responsibility?
A. Typically, I would send out the claim form myself, if it hadn't been received.
Q. But, again, in this case you didn't?
A. I believe I did.
Q. On October 11th, at that time?
A. No. Sometime after that, I did send out the claim form.
Q. When?
A. I'd have to look.
Q. Does your attorney have a document which will show us when you sent out a form?
A. It's not in here, but he should have it because I reviewed that yesterday. I saw that in there.
MR. HENEFER: I'm handing opposing counsel a November 1, 2000 letter Bates number 551. No waiver of the privilege intending by the fancy yellow highlighting, Richard.
Q. I've been handed by counsel, a letter November 1st, 2000. Again, a document I didn't have that didn't make sense to me when I went through, in terms of why forms were then filled out. So this is another document I'd like to

receive a copy of.
It has your signature, and it's written to Mr. Mazzamuto. It's stating that a claim had been submitted to him.
How do you know that a claim had been submitted to him?
A. Could I see the letter? I knew the claim form had been submitted because of the letter that he just showed you that we sent him claim forms. But I had yet to receive those forms.
MR. ANGINO: May I see that letter again?
MR. HENEFER: I'm handing counsel document number 553.
Q. So this particular document said a claim form had been sent at that time. So, you hadn't received the claim form. So you sent a second claim form?
A. Correct.
Q. The next document appears to be a lost file kind of document, carrying number 536 and after that's 535. Do you see those two documents?

A. Yes, I do.
Q. They are carrying the name Michelle Bachini. Both carrying the date of 10/19/2000. They have two different time periods. One's at 9:16:23; the other one 9:28:08 a.m. They both reference Mazzamuto H3236167. Is that correct?
A. Correct.
Q. Is this a form used by UNUM in terms of missing files?
A. Typically, yes.
Q. Do you know what happened, how Mazzamuto's file got missing?
A. I'm not exactly sure, but, at the time the New York Life had just been -- the New York Life block of business had just been forwarded to us from New York. So I believe they were in a different location, and that's what the purpose of this e-mail was.
Q. So, for us to understand the factual circumstances at or about the time when this claim was being made, was there some form of merger or something going on, or a block of business being transferred or something along that line?

A. Yes. We were going to be administering the New York Life Insurance Company disability claims.
Q. That's my next question. I'm going to take you back to the second document from the beginning. If you could just go back to that. Keep going.
The setup forms, there is a whole section called line of business, PLA. What's that?
A. Provident Life and Accident.
Q. PLC?
A. Provident Life and Casualty.
Q. Paul Revere. TNE?
A. The New England.
Q. Equitable. John Hancock. Provident Mutual. MPA? What's MPA?
A. I'm not sure what MPA is.
Q. Northwest. Great West. General American and New York Life. And New York Life is checked; is that right?
A. Correct.
Q. As a claims representative do you work on all these different lines of business?

Page 25

A. No.
Q. I don't see UNUM mentioned there.
A. At the time I do not believe we were handling UNUM. In the Worcester office, I do not believe we were handling the UNUM block of business at the time of this document.
Q. What block of business were you handling at the time?
A. At the time I was handling the New York Life.
Q. Just the New York Life?
A. At the time, correct.
Q. And how did this happen to go from New York Life to UNUM, this block of business, so to speak that involved Mr. Mazzamuto?
A. The name of our company is UNUMProvident. So I'm --
Q. Did they buy New York Life as far as you know?
A. I'm not positive of the legalities of it, but I know that we were administering the block of business.
Q. So you were administering both New York Life and UNUM business?

Page 26

A. UNUM at the time, I do not think so. Paul Revere, yes.
Q. So you were handling New York Life and Paul Revere. Any other companies?
A. At the time, I do not believe I was handling Paul Revere. But I was prior to New York Life. Then I began handling New York Life.
Q. Okay.
A. No other blocks of business.
Q. The next document I'm looking at is carrying a date of November 3rd, 2000. Do you see that?
A. Yes.
Q. Is there any letter that you have in your file that would have preceded or brought this response from the doctor, of which you're aware of?
A. I believe -- I believe this was after my telephone call with Mr. Mazzamuto where he asked me to contact his attorney's office to get this document.
Q. No, that would have been in January. This is a November document.
A. I understand. But this was in

Page 27

Mr. Russo's office. That was not given to me at the time of claim. Mr. Mazzamuto indicated to me that he did not have him send it with the claim form.
Q. But this has been sent, it's carrying the date of November 3, 2000. It went to New York Life Insurance Company.
A. Correct. It was faxed to me on January 4th, at the top.
Q. But what I'm saying is, do you know why something that went to Paul Revere and New York Life didn't come to you prior to January?
A. The only thing I know is from what Mr. Mazzamuto told me. It's documented in my phone conversation. That he indicated to his attorney's office -- actually, I'm sorry. His attorney indicated to him that they did not need to send this because it was regarding a back condition and he was filing a claim for a heart condition.
Q. My point, though, is: You're not questioning that on November 3rd this particular letter went to Paul Revere and went to New York Life?

Page 28

A. I do not believe this went to the Paul Revere Life Insurance Company. I believe this went to Mr. Russo's office. I did not receive this claim form until Mr. Russo's office gave it to me on January 4th.
Q. I know, but are you saying a letter was prepared and wasn't sent?
A. Correct.
MR. HENEFER: Objection. I think she said that it was sent to Mr. Russo's office.
THE WITNESS: Correct.
MR. HENEFER: It was provided to Mr. Russo.
A. It wasn't provided directly to me.
Q. My point, though, is, is there a New York Life Insurance Company at 51 Madison Avenue, New York, New York?
A. Yes.
Q. Is there Paul Revere Life Insurance Company, New York Life customer care center?
A. Correct.
Q. And is it a P.O. Box 15001, Worcester, Massachusetts?
A. I believe so. I'm not sure of the

Page 29

exact P.O. Box address.
Q. You said one of your servicing companies or lines of business is Paul Revere. Is that right?
A. Correct.
Q. And do you have any knowledge as to whether Paul Revere has a P.O. Box?
A. Yes, Paul Revere does have a P.O. Box.
Q. And as far as you know, would this be the P.O. Box 15001?
A. That would be a guess.
Q. Your attorney is writing down, and what I'd like to find out is if Paul Revere and/or New York Life Insurance Company received this letter in November. You know, you received it in January. But I'd like to know if they received it?
A. Okay.
Q. Okay. Whether they received it and didn't send it to you or whatever happened, the letter does seem to indicate that the doctor is saying what is wrong with Mr. Mazzamuto. Is that right?

Page 30

A. Correct.
Q. And he goes on to say, "I find it difficult to coherently fill out the forms as his medical problems are several."
Do you see that?
A. I do see that.
Q. So knowing the English language, apparently this doctor had received certain forms to fill out. Is that right?
A. Correct.
Q. And he says, "Mr. Mazzamuto has had a long history of low back pain." That's what he first says?
A. Correct.
Q. Is that what he says?
A. Yes.
Q. And in terms of describing injuries, is that the first injury that he described, Mr. Mazzamuto has had a long history of low back pain"?
A. Correct.
Q. "And, in fact, for many years has undergone numerous treatments and physical therapy and MRI in the past did reveal central

Page 31

spinal stenosis which gradually worsened to a maximum L3-L4 and extends to L2 to L5." Do you see that?
A. Yes.
Q. "This has given him periodic problems with lower back discomfort, symptoms of radiculopathy and urinary irritability."
Do you know what those words mean?
A. Some of them. Not all of them.
Q. He's saying that he's had lower back discomfort; he's had radiating pathology, means disease; and urinary irritability. Do you see that?
A. Yes, I do.
Q. "Prolonged standing and heavy lifting have aggravated. He has been seen in physical therapy; treated in a local pain clinic with local injections as well as prescription analgesics, nonsteroidal anti-inflammatory agents and other atypical chronic pain medications." Do you see that?
A. Yes.
Q. You agree, all that deals with his back; is that right?

Page 32

A. Correct.
Q. And all of that is communicating to Paul Revere and New York Life Insurance Company, Mr. Mazzamuto has a back problem. Is that right?
A. Correct.
Q. It then goes on to say, "Mr. Mazzamuto's condition was complicated this year." Is that right?
A. Yes.
Q. And then he discusses the heart situation. Is that right?
A. Yes.
Q. Goes on to talk about a readmission; is that right? Third paragraph.
A. Yes, I see that.
Q. He then goes on and says, "As the patient has attempted" -- Do you see "attempted to return to work"?
A. Yes.
Q. -- "after his recovery from his heart attack, his back was worsened again." Is that what he says?
A. Correct.

Page 33

Q. "Also the stress and anxiety which has been provoked because of his recent cardiac problems and manifested themselves with significant anxiety when he is back in work conditions." Do you see all of that?

MR. HENEFER: Actually, "work situation."

Q. "In a work situation." Do you see that?

A. Yes.

Q. Are you aware that your insurance company took the deposition of the doctor who authored this report?

A. Yes.

Q. And have you been told what the doctor said?

A. No.

Q. When you get a copy of the deposition, I'm going to basically state for you to assume that he said the same thing in his deposition now as he said back on November the 3rd, 2000.

A. Okay.

MR. HENEFER: I just want the record

Page 34

to reflect that the Plaintiff's Exhibit 1, does not have a second page of Dr. Bower's November 3rd letter.

MR. ANGINO: I think it's just his name. Is there more?

MR. HENEFER: No. Actually there's quite a bit of information on it.

MR. ANGINO: Let's make it complete then.

MR. HENEFER: I'm a little confused about your last instruction about assuming what Dr. Bower said. I want to note an objection on the record to that.

MR. ANGINO: That's fine.

Q. The second page of the letter, and we do want it to be complete, it says, "While his heart condition has currently stabilized and should hopefully not pose a great limitation on him in the future, the amount of weight he has gained from his smoking cessation has exacerbated his chronic and progressive back problem. At the present time he is not able to do the work required in running his restaurant because he cannot stand for a prolonged period

Page 35

of time; has difficulty bending and is restricted from heavy lifting. It is unlikely he will be able to return to work in the foreseeable future."

Is that what Dr. Bower told New York and Paul Revere in a letter of November 3rd?

A. Yes.

Q. So that obviously your attorney has made a note, and if New York Life and Paul Revere got that letter in November, they would have known from that time what Dr. Bower said with regard to disability; is that right?

A. If it was received by Paul Revere.

Q. There is, however, the next document which is an UNUM document, as I see it. A single-page document.

A. I believe our documents are out of order from each other because I have a different document.

Q. Which one do you have in between?

A. The telephone conversation.

Q. Yours are probably in better order than mine.

A. Okay.

Page 36

Q. Let me take a look at yours. Yes, yours is out of order. That's a January date. Put it to the side until we get to that.

A. Sure.

Q. The next document is carrying a date of November 15th. Do you see at the bottom of that page?

A. I see that.

Q. So whether or not New York and Paul Revere received the letter of November the 3rd in the normal course of mail delivery, there is no question that there is a document by UNUM dated by Dr. Bower, 11/15/2000. Is that right?

A. Correct.

Q. And that document when it talks about subjective symptoms talks about anxiety. Is that right?

A. Yes.

Q. Which is in the letter of November 3rd; is that right?

A. Correct.

Q. It talks about worry, which anxiety and worry is in the November 3rd letter; is that right?

Page 37

A. I'm not sure if worry. But I remember anxiety.
Q. Low back. Do you see that?
A. I see that.
Q. And these are the symptoms that are mentioned; is that right?
A. Correct.
Q. There's no symptom mentioned there with regard to the heart, is there?
A. Symptoms, no.
Q. Symptoms are anxiety, worry, and low back. Is that right?
A. Correct.
Q. And objective findings is the cardiac catheter; is that right?
A. Correct.
Q. The restrictions are no prolonged standing, no heavy lifting. Do you see that?
A. Yes.
Q. And do you see where it says "secondary to back"?
A. Second to back, yes.
Q. And when he's telling you what the limitations are, he's saying cannot work in

Page 38

stressful situations. Do you see that?
A. Yes.
Q. And it goes on to say that the date of his first visit for this particular condition is 7/22/2000. Is that right?
A. Correct.
Q. And date of the last visit was 10/04/2000. Is that right?
A. Correct.
Q. And it goes on to be signed by Dr. Bower and dated by Dr. Bower. Is that right?
A. Correct.
Q. So he's saying he can't work in stressful situations; right?
A. Correct.
Q. The next document is actually a medical provider's statement. Can you tell me the difference between the document that's called an attending physician's statement and a medical provider's statement?
A. I believe this was the form that the UNUMProvident Corporation used. And this is the form that the New York Life Insurance Company

Page 39

used. And it appears he completed both forms.
MR. HENEFER: The record reflect, the New York Life is the one entitled "Medical Provider's Statement."
THE WITNESS: Correct.
Q. Again, obviously, the doctor has received a New York form. Is that right?
A. Correct.
Q. Would that tell you something as to whether or not he sent a letter to New York Life?
A. That would be an assumption. I'm not sure.
Q. But, would you assume from your practice of being a claims rep that if someone fills out a form, that somebody sent him a form to fill out?
A. Correct.
Q. That's what I'm saying. Somebody would have had to have sent him a form from UNUM and somebody would have had to send him a form from New York Life. You don't think he did this on his own, do you?
A. No.

Page 40

Q. So, do we have any letter showing UNUM sending him a form and New York Life sending him a form?
MR. HENEFER: Yes, we referred to the New York Life letter previously. And there's a UNUM letter.
MR. ANGINO: Of the same type.
MR. HENEFER: Of the same type dated September 28, 2000, Bates number 554, which says among other things "enclosed please find a claim form."
MR. ANGINO: Okay, so as we go through this deposition we'll have the things I'm missing, and we can fill those in hopefully at that point.
MR. HENEFER: I'm disappointed to hear that there's pages missing from the document production, Richard. Rather than have somebody from your office go through and make sure that each numbered pages -- each of the numbered pages are missing or not missing, apparently there's some gaps in this. I'm seeing in the exhibit, you know, you have number 551, then 555, and my file has the intervening

Page 41

documents.
So what I will do is, I will just have a complete new set of this made and ship it back out to you.
MR. ANGINO: I appreciate that.
(Discussion off the record.)
Q. We have what you said is the New York Life document.
A. Correct.
Q. And obviously you had, in your file, both the New York and the UNUM forms; is that right?
A. Correct.
Q. So you had the information that was in both of these; is that right?
A. Yes.
Q. And, in terms of the medical provider's statement, there are primary diagnoses that are in numbers. Do you know what those numbers mean: 414.01?
A. I don't know what they mean.
Q. And there are other numbers there, I assume that they're probably correlated with certain medical conditions. Is that right?

Page 42

A. Correct.
Q. And when the New York form asks, "when the symptoms first appear," and says "7/22." Is that right?
A. Correct.
Q. And that's consistent with the UNUM form; is that right?
A. Yes.
Q. And it goes on to say about treatment. And that would be consistent with the UNUM form, when he was treated. Is that right?
A. Yes.
(Discussion off the record.)
Q. Back on the record. It goes to the second page of the New York form. And it says, number 15 -- I'm sorry, number 13. "In your opinion is the patient able to work at this time?" And he put a circle for "no."
First there was a mark, but that was crossed out.
He then goes on to say, "based on objective findings in your medical opinion the patient was unable to work from July the 22nd to

Page 43

the present." Correct?
A. Correct.
Q. Then goes through the restrictions; is that right?
A. Yes.
Q. And, apparently, was filled out and signed the same day, 11/15, for both of these documents. Is that right?
A. Yes.
Q. So he's telling the insurance company, this man hasn't been able to work, he's been disabled, and he's been disabled for three or four months. Is that right?
A. Correct.
Q. The next form is the disability form which we've all been talking about in terms of the claims form. Is that right?
A. Correct.
Q. And that, likewise, apparently was filled out on the November 22nd. Is that right?
A. Yes.
Q. And that particular document is carrying a Bate stamp, somewhere, I assume. Is that 22023, could that be it? At the bottom?

Page 44

MR. HENEFER: No. That's not it. In the Bates labeling that document would be Bates number 544 and 543.
Q. Do you know when this particular document was received?
A. This particular document, no. I believe one of them was received on December 15th, but I'm not sure.
Q. This one's carrying a date of November 22nd. Right?
A. Correct.
Q. And the next document that you see is also carrying a November 22nd date. Is that right?
A. The day Mr. Mazzamuto signed it, correct.
Q. And this is the employer section; is that right?
A. Yes.
Q. And there's another document --
MR. HENEFER: That last document, just so the record's clear, Bates number 548 and 547. Sorry for interrupting.
MR. ANGINO: Please do. There is

Page 45

another document, what is that document Bate number?
MR. HENEFER: That is numbers 540 and 539.
Q. Apparently, Mr. Mazzamuto is getting forms from different companies to file. Is that right?
A. It appears.
Q. The first one is New York. The second is UNUM. The third is New York. Is that right?
A. Correct.
Q. Is this some kind of company mix-up, or should he be receiving forms from two different companies?
A. No.
Q. What happened?
A. I have no idea. I didn't send them. The New York forms, I didn't send him.
Q. So somebody sent him New York forms. Did you send the UNUM form?
A. I did send one UNUM form after I did not receive the form that our intake department had given him.

Page 46

Q. But you didn't send this one?
A. It would look exactly like that.
Q. But you didn't send this one, though, that is signed November 22nd?
A. I don't know which one he completed. But they look exactly the same.
Q. Okay. Well, the third form, which, please, assist me again?
MR. HENEFER: This is the insured's statement of occupational duties and employment.
MR. ANGINO: Right.
MR. HENEFER: That is 540 and 539.
Q. He says, "I cannot perform my duties under the stressful situation. My chest is painful and I am fearful for my life." Is that what it says?
A. Yes, it does.
Q. Next form, seems to have been cut off, doesn't seem to have any great importance at this point. The next document is where this one comes in that you had been holding out.
A. Okay.
Q. By this time -- and "by this time" I'm talking about this document of January 4th

Page 47

of '01?
A. Mm-hmm.
Q. Yes.
A. Yes. I'm sorry.
Q. New York Life, UNUM, Paul Revere, whatever we have documents that go back to September; is that right?
A. Yes.
Q. So, October, November, December, January -- four months have gone by. Is that right?
A. Not since I received the claim form, but.
Q. From the documents that we have. The first one's September 9th. And you're now at January 4th. Is that right?
A. Yes.
Q. Okay. What I'm suggesting to you is if we count the months, it's five days shy of four months. Is that right?
A. I'm confused on what you mean, count the months.
Q. The very first intake form was 9/6/2000?

Page 48

A. Correct.
Q. If you go to January 4th of 2001, it's two days short of four months?
A. Yes.
Q. Okay. That's all I'm saying.
A. Okay.
Q. And your phone conversation then was, the first, at least recorded phone conversation that at least I have. Do you have any other phone conversation documentation?
A. This is my first conversation with the insured.
Q. Okay. So you were assigned this claim on October the 10th?
A. Correct.
Q. What did you do from October 10th, November 10th, December 10th to January? What did you do for three months?
A. I was waiting for the claim form. We don't contact our insureds until we actually have the claim forms in our hand.
Q. So, is there any policy or procedure set up when you are assigned a claim to wait three months to do something?

Page 49

MR. HENEFER: Objection. You can answer.
Q. You can answer.
A. I don't believe there's any policy, but from what I've been told, we would wait until we have the claim form so there's something to discuss.
Q. Do you know what happened to this -- these forms that are all carrying dates of November 15th from the doctor and November the 22nd from the claimant?
A. If you see one of the documents has a date stamp of December 15th, that's when it was actually received in our company.
Q. One of them. What about the other ones?
A. They were attached.
Q. So what about the doctor's form?
A. They were all attached.
Q. So all of this came in on December 15th, as far as you know?
A. Correct.
Q. Was there any transmittal letter or anything that accompanied them?

Page 50

A. Not that I recall.
Q. So, what you're saying is although the case was assigned to you in October, if they didn't send it for a year, you'd just keep waiting?
A. No, I would follow up as I did. Follow up in writing for the claim form.
Q. When?
MR. HENEFER: When did she follow up? Or when would she?
MR. ANGINO: Yes. When did she.
MR. HENEFER: When did she. I think we referred to that letter earlier.
THE WITNESS: Yes.
MR. HENEFER: I don't want to interfere, but I think we referred to her November 1, 2000 letter, which was Bates number 551.
Q. That was my point, though, from that November 1st date --
MR. HENEFER: Until the claim forms was received.
Q. -- until the claim forms was received, was a period of at least six weeks; is

Page 51

that right?
A. Correct.
Q. And you didn't follow up during that six-week period?
A. I don't know if I did or not.
Q. I mean, we have no letter either in my files or in your counsel's files?
A. Correct.
Q. And we have nothing that shows that you did anything on this file at least for a two-month period, from November, saying send me -- here's a follow-up form, or second form, until January the 4th. Is that right?
A. Correct.
Q. Can you tell me whether that's your normal practice?
A. It's not normal practice to do -- What is your question? I'm sorry. The normal practice --
Q. Would your normal practice, if you have a file that's been assigned to you to wait two months before you do something else on that file?
A. No, it's not normal practice.

Page 52

Q. That wouldn't be normal practice, no. I assume just from talking to you, you'd like to move these files along; is that right?
A. Correct.
Q. And the law requires that you move files along?
MR. HENEFER: Objection.
Q. Do you understand that?
A. I'm not sure of the specific laws.
Q. Okay. Are there procedures and protocols within the companies that you work that require you do something in a two-month period like this?
A. The only procedure I'm aware of is after receipt of claim forms, when we will contact insureds.
Q. So, just for the sake of argument, if claim forms didn't come to you for a year, I mean, you feel it would appropriate not to do anything until you receive those claim forms?
A. I don't feel that it would be appropriate, no.
Q. Sure. So, after this phone call in January, we now have something called an action

Page 53

plan. Is that right?
A. Correct.
Q. And that's carrying the date of January the 8th of '01. Is that right?
A. Correct.
Q. Would this in your normal situation, and I'm gathering Mazzamuto isn't quite normal, you, in being a conscientious employee would want to have an action plan from the time that you would have a file assigned to you. Is that right?
A. No.
Q. No, you wouldn't. Okay. Go ahead. Tell me.
A. If I didn't have the claim forms, there wouldn't be an action. I wouldn't know, waived on -- I didn't have any types of documents in the claim file. I would complete this after I had reviewed the documents and spoke to the insured.
Q. So, it's very important that you get that claim form. Is that right?
A. Correct.
Q. I mean, until you get that claim

Page 54

form, everything else is being held up; is that right?
A. Correct.
Q. You need the claim form to prepare the action plan?
A. Yes.
Q. Okay. So that, you received at least in a documented fashion, December 15th, is that what you said?
A. That's when it was received at our company.
Q. In your company, it was received on December 15th. How about you personally?
A. I'm not sure when I personally received it. It would have been within -- I'm assuming a couple of days from December 15th.
Q. Okay. But it was followed up with a call on January the 4th, and then an action plan on January the 8th. Is that right?
A. That's right.
Q. Now, one of the first things -- and I have these attached for a reason. Part of the action plan involved finding out if there had been a former claim. Is that right?

Page 55

A. It wasn't part of the action plan, but it was -- I did follow up -- we did follow up for the prior claim.
Q. There is a request on January the 9th at 9:15 a.m. with a Bate stamp of 236 to the records operations in Chattanooga. Is that where the records of kept in Chattanooga?
A. I believe so, yes.
Q. All right. Did you make this claim request or did somebody else? It says Robin Andrews, what's that?
A. She was my claim assistant at the time. But I would have asked her to get that.
Q. So you asked Robin to get the prior claim form. And that's why you are being copied with it. Is that right?
A. Correct.
Q. And what you actually receive therefore is disability claim information, which is the next page, which is carrying a Bate stamp of 233; is that right?
A. Correct.
Q. And it's telling you that he had a low back pain with a central spinal stenosis

Page 56

back in April the 13th of '96. Is that right?
A. Correct.
MR. HENEFER: Off the record for a second.
(Discussion off the record.)
MR. HENEFER: Back on the record.
Q. Back on the record. You received not only these three pages that are here, but the entire claim file. Is that correct?
A. Correct.
Q. And we'll come to that later in the questioning process but I'm glad that defense counsel has made it clear that you knew all that was in that prior claim form file in January of 2001; is that right?
A. That's right.
Q. And, therefore, knowing that, you had access to, in January of 2001, medical records. Is that right?
A. From the prior claim?
Q. From the prior claim?
A. Yes. Whatever was in the claim file.
Q. And we'll get to that. But if there are medical records, you had access to them. Is

Page 57

that right?
A. If there were medical records, if they were in there, yes, I would have had access.
Q. You would have had access to the fact that -- would it have been New York Life at that time?
A. Yes.
Q. That New York Life was attempting to not pay the claim based on fraud. You would have had that access to those records?
A. I believe so, yes.
Q. You would have had access to the record that they were investigating nonpayment to the point where the agent who had written the policy communicated with New York Life. Is that right?
A. Yes.
Q. You would have had the access to the records that concluded that they had no basis for denying the claim?
A. Yes.
Q. And the conclusion was that they had no basis for denying the claim, not only as to

Page 58

fraud, but also as far as disability, you had access to those documents?
A. I'm not sure what the documents said, but I do realize that they didn't -- remember that they didn't pursue it. I'm not exactly sure what the document it.
Q. Well, we can go a little bit out of order here. There is a particular document that looks like that. If you go through your series of files, and I think your attorney has come to that particular set of documents.
A. I found it.
Q. Kind of just put that sideways, we'll go back to those. You see this stack of documents which has a large black clip and it has a smaller clip there?
A. Yes.
Q. I'm suggesting that this packet of documents appears to be a packet of documents that deal with the other claim --
A. Yes.
Q. -- would you agree?
A. I agree.
Q. And they do have physician's

Page 59

statements and things such as that.
A. Yes.
Q. I'm going to suggest to you that in response to a question that I asked you, if you go back five pages, you will see something called "Claim Referral Memoranda." Back from the back, from the rear.
A. Okay.
Q. You have that. My question to you was that they determined that they had no basis for denial either on fraud or on the basis of disability. And I'm going to read to you that claim referral memorandum, which carries the date of 4/16/97.
"Please see response of 3/7/97. This is to McCarthy from Gloria Phillips" --
MR. HENEFER: Phelps.
MR. ANGINO: Phelps. I'm sorry. Please see your response of 3/7/97 to my 3/7 referral and note OGC." Can you tell me what that is?
A. I don't know.
Q. Okay. "Reply of 4/15/97 to my memo of 7/11/97" --

Page 60

MR. HENEFER: 4/11.
MR. ANGINO: Is that 4/11/97?
Q. -- "since we can't deny on PE." Physical exam, is that what that is?
A. I'm not sure.
Q. He's saying, though, "we can't deny on PE"; right?
A. Mm-hmm.
Q. -- "or rescind on fraud provision. I am recommending we accept liability for the period of TD." Do you see that?
A. Yes.
Q. So, when I had asked you before about after attempting to deny on fraud, they couldn't deny on physical exam or whatever PE stands for, they paid the claim. Is that right?
A. Correct.
Q. Now, as far as you know that prior disability involved the back, did it not?
A. Correct.
Q. And it involved a stenosis, at least to some extent because that was the basis upon which there was attempted denial on the basis of fraud. Is that right?

Page 61

A. Correct.
Q. That the stenosis had not been revealed in the original application; is that right?
A. Yes.
Q. Do you know what stenosis is?
A. I'm not a hundred percent positive. I have an idea, but.
Q. Okay. But you do understand that the reference to L numbers or lumbar numbers?
A. Yes.
Q. They do involve the back?
A. Yes.
Q. So that as far as you knew back in 1996, Mr. Mazzamuto had a back problem. Is that right?
A. Correct.
Q. And made a claim for a back disability; is that right?
A. Correct.
Q. And was paid by New York Life on the basis of that back disability. Is that right?
A. Correct.
Q. You had, in your possession as of

Page 62

January documents from his same doctor, Dr. Bower; is that right?
A. Yes.
Q. Saying that the back condition has worsened over the years; is that right?
A. I don't remember what the --
Q. Well, they say what we went through that they said. Is that right?
A. Are you talking about the documents I received, or the first documents?
Q. The first documents that we went through. I'm talking about all the documents that we've gone through in this deposition.
A. Yes, it did say that.
Q. As far as you knew in January, Mr. Mazzamuto was doing the same kind of work in 1996 as he was in 2000. Is that right?
A. Correct.
Q. So, if he was doing executive or administrative or standing or sitting, as far as you know, it was the same kind of work; is that right?
A. Yes.
Q. So, New York Life in 1996 from your

Page 63

review of the documents did not contend that his back condition did not disable him for the type of work he was doing. Is that right? Did you see anything in the documents that contended to that?
A. No, I didn't.
Q. So, the situation is as of January he's making a claim through his own application and through his doctor's filings that he can't do the work because of his back condition, because of anxiety, because of fear. Is that right?
A. Yes.
Q. What happens then is that you write a letter on January 15th, which, again, I can't find a Bate stamp number.
MR. ANGINO: Off the record.
(Discussion off the record.)
MR. HENEFER: Back on the record.
The January 15th letter, the numbers are 530 and 529.
Q. This letter came from you; is that right?
A. Correct.

Page 64

Q. And you're saying at the outset that you are going to explain the status of his claim. Is that right?
A. Correct.
Q. And the first thing you do is explain that there is a 90-day elimination period. Is that right?
A. Yes.
Q. And if everything went the way it was intended to go, he should have been receiving payments that would have started as of a disability occurring on October 20th?
MR. HENEFER: Objection to the form.
You can answer.
A. If he was eligible for benefits then benefits would have began to be -- the paid to date would be October 20th -- I'm sorry. The beginning date would be October 20th.
Q. That was my question. Now, you state that the policy requires written notice of a claim must be given to us within 30 days after a disability starts. Is that what you said?
A. Yes.
Q. There's mention of an oral notice in

Page 65

July, at least in Russo's letter. Is that right?
A. That's right.
Q. You did have written or some form of verification of the notice as of September the 6th; is that right?
A. I do not believe I received written notification of claim until December 15th.
Q. Well, what you're saying is written notice. Is there a difference between a notice and an actual claim form?
A. Yes, but I don't believe I received a written notice of claim. I don't recall.
Q. Well, you mean if --
A. Verbal.
Q. You mean if an insured calls you, and you've recorded it --
A. That's not written notice of claim.
Q. That's not written notice of claim. So did you see anything in any of the intake forms where someone in the intake department wrote to Mr. Mazzamuto or Mrs. Mazzamuto and said calling us is not enough, you've got to send us something in writing. Did you see

Page 66

anything like that?
A. No.
Q. But, what you're saying, in your January letter, is the fact that you called and you called potentially three times -- I'm just saying potentially. If we assume there's a call in July, there's a call on September the 6th, there's another call on July 8th or 9th. You're saying these calls aren't notice. Is that what you're saying?
A. I didn't say it wasn't notice. I said it wasn't written notice.
Q. Are you saying it's a difference whether somebody calls on the phone or writes?
A. I'm saying that verbal notice isn't a written notice. That's all I'm saying.
Q. Does it result in any different handling of the file whether someone calls or writes?
A. No. I was just letting him know that the policy --
Q. He didn't send a written notice?
A. Correct.
Q. You're just letting him know that he

Page 67

didn't send a written notice?
A. Correct.
Q. And that's what's required under the policy?
A. Correct.
Q. And you're saying because he didn't send a written notice within the time frame the evaluation may be delayed?
A. Correct.
Q. Why? Why would you delay something if someone calls you rather than writes to you?
A. That's not what the statement said. I said, "our evaluation may be delayed." I was just letting him know that sometimes my statement -- my statement meant sometimes information may take longer to gather, seeing there was months of documents we needed.
Q. But my question is very simple. "As your written notice was not submitted within this time frame, our evaluation of your claim may be delayed."
Can you tell me how a written notice or an oral notice would change an evaluation?
A. Written notice, we would have an

Page 68

authorization which would allow us to get medical records so on and so forth. With the verbal phone call, there is no documents that we could even obtain.
Q. If I -- if Mr. Mazzamuto or Mrs. Mazzamuto instead of calling sent you a note, my husband was disabled as of July the 27th, how would that give you any authorization?
A. It wouldn't.
Q. Well, you're saying here, written notice was not submitted. Written notice can say exactly the same thing as oral, can it not?
A. Our company does have written notice of claim forms. It's a different form than this. They're provided those forms with their -- I believe, with their -- when they're issued their policy. I know for UNUM we have those, and they do have an authorization. I'm not sure if he was given those forms or not, though.
Q. Well, what I'm saying to you is you don't know if he was given the forms, you don't know if he kept the forms?
A. Correct.
Q. How is this man to know when you say

written notice of claim, this is referring to a specific designated document rather than something being in writing rather than oral? How would he know that?

A. He doesn't know. But we didn't receive his claim form.

Q. Now, you then go object to say "please note that we have requested your medical records."

A. Mm-hmm.

Q. If I received this, I would have thought you had just requested his medical records. When had you first requested his medical records?

A. I would have to look through the file. That would be in the file.

Q. Well, don't you think this paragraph is a little, I would say, deceiving?

MR. HENEFER: Objection.

A. No, I don't.

Q. "Please note that we have requested your medical records from Dr. Douglas Bower and Carlisle Hospital. This information is needed." You're saying this information is

needed; is that right?

A. Correct.

Q. You had already received, you said, on December the 15th?

A. Those were not medical records. That was the claim form. That was a medical provider's statement. Medical records are different.

Q. Are you saying if a doctor sends you a letter of November the 3rd, the doctor sends two different physician's statements, medical provider's statements, that those aren't medical records?

A. Correct. Complete medical records.

Q. Well, is there some reason, if you wanted complete medical records, you didn't ask for complete medical records when you took over the file?

A. I believe I did.

Q. Well, do you have something here showing when you wrote to Carlisle Hospital and you wrote to Dr. Bower for records?

A. Yes, I do. I believe it's in the file.

Q. Can I see it?

A. Here they are. I gave this form to my claims assistant, who then requested the medical records. And here are the requests. They're all in these. They go from there to.

Q. What are the dates, please?

A. I gave this internal medical records request to my claims assistant on January 15th, 2001. And she then sent letters to his -- to Dr. Douglas Bower and to the hospital on January 22nd, 2001.

Q. That was my point.

A. I'm sorry. I didn't know you didn't have the documents.

Q. My point is, a man calls up, or his wife calls up in July.

A. Mm-hmm.

Q. Calls again twice in September. What would it take you to send him a medical authorization?

A. We did send the claim forms, which on -- if you see the claim form, there's an authorization on the back of the form.

Q. Did he complete those?

A. Yes. I did not receive that until December 15th.

Q. So, why do you go from December 15th to January 15th to send for the medical records? Why a month?

A. I don't know.

Q. I mean, these are all forms; is that right?

A. Correct.

Q. So, I mean, at worst, you get things in December 15th because there's not been follow-ups you know from October 11th, when you were assigned the file --

A. Mm-hmm.

Q. -- but here's another month goes by and this man is not working according to what you know. Is that right?

A. Correct.

Q. I mean, I don't want to be flip or anything, and your attorney can make an objection, and the judge could make a decision on the particular issue. You realize when people take out disability insurance, that it's taken out for the purpose of being paid if

they're disabled?
A. Correct.
Q. And they need that money when they're disabled. Is that right?
A. That would be an assumption, but.
Q. And a month without a paycheck, would you think, would be a meaningful thing?
A. I'm not sure.
Q. Would a month without a paycheck be something meaningful?
A. No.
Q. Three months without a paycheck, would that be meaningful to you?
A. I'm not sure I understand the question.
Q. Well, what I'm saying is people take out disability insurance. Is that right?
A. Correct.
Q. And back in 1996 when Mr. Mazzamuto first had a claim, he had a six-month waiting period; do you remember?
A. No, I don't.
Q. Do you know that he changed it from six to three months because he didn't want to go

longer than three months without a paycheck. Did you know that?
A. I don't recall.
Q. Okay. We'll get to that?
A. Okay.
Q. In the form of letters.
A. Sure.
Q. But, we have a situation where phone calls are made in September, and we're now in December 15th. And you admit that at least as of that time you have the forms you need to go ahead with an action plan, but another month goes by before there's a request for medical records; is that right?
A. Correct.
Q. And you go on to tell him, "this information is needed before we can determine our liability." Is that right?
A. Correct.
Q. And you're now also sending him an occupational description form in full. Is that right?
A. Mm-hmm.
Q. Yes.

A. Actually, we asked for him to complete it in full.
Q. Right. You had previously sent him an occupational form that he had completed; is that right?
A. Yes.
Q. Why do you need another one?
A. The second form we sent him was more specific. It was just to obtain further clarification.
Q. Why did you send him the more specific one at first?
A. We wouldn't have known we needed more specific occupational information until we reviewed the prior one that he submitted.
Q. And now you're asking for a progress report. Is that right?
A. Correct.
Q. The forms you received were dated November 15th by the doctor. Is that right?
A. I believe so.
Q. What did you think had happened between December -- between November 15th to January 15th?

A. I wouldn't know what had happened. That's the purpose of having him complete an additional claim form.
Q. And is there a policy at New York and UNUM as to how often you're going to have these doctors fill out these forms?
A. There isn't. But his policy requires proof of loss.
Q. How often do you send them out?
A. Each claim is handled on its own individual basis. But policies are payable at the expiration of 30 days subject to proof of loss.
Q. I went through a whole series, it seems like you're asking this doctor every month to fill out a form; is that right?
A. I don't recall.
Q. So that, do you think that's a little burdensome every month for a doctor to fill out a form?
A. No.
Q. Next thing we see is a monthly progress report; is that right?
A. Correct.

Page 77

Q. And it's dated January 16th; is that right?
A. Yes, that is right.
Q. My gosh, send out something on January 15th, and you have something on January 16th?
A. No, I didn't get this, I believe, until the 22nd.
Q. No, but I'm saying it's signed the very next day, January 16th is it not?
A. Correct. I could have overnighted it to him. I'm not sure. That would be an assumption.
Q. So if you overnighted something on January 15th, you felt it was an important thing to get. Is that right?
A. That would be an assumption.
Q. Well, what we have is at least acknowledgment that there's a monthly progress report dated January 16th. Is that right?
A. Signed by him on January 16th, correct.
Q. And I don't have a Bate stamp for that.

Page 78

MR. ANGINO: Do you have a Bate stamp for that? I'm sorry for this, but.
MR. HENEFER: I don't. I don't have that.
Q. All right. Well, if we keep them in the same order, we'll know what they are. We have another attending physician's report, January 18th. Is that right?
A. Correct.
Q. And if you were to take that statement and go back to the November statement --
A. Which statement are you referring to?
Q. Attending physician's statement, which is dated January 18th with the UNUM statement. They're both called attending physician's statements; is that right?
A. Correct.
Q. He told you back on November the 15th, that the subjective symptoms were anxiety, worry, low back pain. Right?
A. Correct.
Q. On January 18th, he says, "CAD S/P non QMI, chronic low back pain, anxiety." Is

Page 79

that right?
A. Correct.
Q. So he's telling you basically the same thing. Is that right?
A. The CAD is a little bit different. But the chronic back pain and anxiety, those are the same on both forms.
Q. I think in the first form, it appears as objective findings, cardiac, do you see that under there?
A. Yeah. The CAD and cardiac cath are different.
Q. He's telling you this man has chronic, do you know what the word "chronic" means?
A. Yes.
Q. What does it mean?
A. It's there all the time.
Q. Sure. So, if he had chronic pain in November, he's got chronic pain in January. He had anxiety in November. He has anxiety in January; right?
A. Correct.
Q. As far as his office visits, there

Page 80

were two more visits. November 29th and December 19th. Is that right?
A. And January 11th, it looks like.
Q. Okay. And January 11th.
MR. HENEFER: Off the record for a second.
(Discussion off the record.)
Q. In November, he says, he cannot work in stressful situations. Is that right?
A. That's right.
Q. And here he's telling you, "unlikely to be able to return to his work secondary to back." Is that right?
A. That's correct.
Q. So, now, you receive by a January 18th date, at least these two UNUM forms in addition to the New York forms. And by this time, the November 3rd form. Is that right?
A. Well, I didn't receive this one on the 18th. I received it on the 22nd.
Q. On the 22nd. I said in January.
A. Okay. Yes, I did.
Q. So, as of January, now, you admit that you had this November 3rd letter from

Page 81

Dr. Bower. Is that right?
A. That's correct.
Q. And that November 3rd letter from Dr. Bower -- you have it there?
A. I have the first page, not the second page.
Q. That's fine. Was descriptive of a long history of low back pain. Is that right?
A. Correct.
Q. With many years of numerous treatment. Is that right?
A. Yes, that is correct.
Q. Physical therapy, MRIs, et cetera. Is that right? Physical therapy and MRI in the past.
A. Correct.
Q. Gradually worsen. Do you know what the words "gradually worsened" meant?
A. Yes.
Q. That it's worse in 2000 than it was before. Is that right?
A. I would assume that he meant something like that.
Q. And he goes on to tell you all the

Page 82

problems coming from that back. Is that right?
A. That's correct.
Q. And you've got now two statements as far as the chronicity, the chronic nature of his back problem; is that right?
A. Correct.
Q. And this back problem back in 1996 in and of itself was sufficient to receive disability payments. Is that right?
A. I believe so.
Q. Why didn't you pay him based on his back problems in January of 2001?
A. We had forwarded his claim file to our in-house medical consultants for review. And as a result of that review, did not feel he was eligible for benefits.
Q. Well, you didn't do that until about two more months later; right?
A. Correct. We waited until we had his complete medical records.
Q. So, the situation is as of January, you now have Dr. Bower giving you multiple attending physician reports as well as that letter of November the 3rd. And you've gotten

Page 83

this more complete occupational description dated January 18, '01; is that right?
A. That's correct.
MR. ANGINO: Do we have any Bate stamp number for that? Occupational description.
MR. HENEFER: Pages 344 and 345.
Q. And Mr. Mazzamuto is asked to describe "How has the disability interfered with the performance of your job?" Is that right?
A. Yes.
Q. "Please describe, sitting standing and walking requirements and limitations." Do you see that?
A. Yes, I do.
Q. He says,"my job requires me to stand most of the time." Do you see that?
A. Yes.
Q. "I am always stressed." Do you see that?
A. Yes.
Q. "Which causes tightness in my chest. Then I have chest pain and shortness of breath. Also, by standing, my back problem is aggravated. I have been under treatment for

Page 84

back pain since 1996."
So, in his own layman-like way, did he tell you why he's disabled?
MR. HENEFER: Objection to the form of the question. But you can answer.
A. I believe he answered the question how has the disability interfered with the performance of your job.
Q. His doctor says he can't stand for long periods of time. Is that right?
A. I believe so.
Q. His job is stressful and causes him anxiety. Is that right? Is that what the doctor says?
A. I believe he gave a finding of anxiety.
Q. "Chronic low back pain, anxiety." Is that what he says?
A. Yes, he says that.
Q. And here's a treating doctor, who's been treating him throughout this entire period of your records, at least from '96 to the present, saying he's disabled. Is that right?
A. That's correct.

Page 85

Q. And as of January 18th, which is the date of this particular document, you hadn't decided to pay him. Is that right?
A. Correct.
Q. So, we then have January 22nd. This is where Mr. Fogarty gets into the picture. Or had Mr. Fogarty been in earlier than this?
A. I believe this is the first time he looked at the claim file.
Q. What is Mr. Fogarty's position in relation to your position?
A. I believe Mr. Fogarty reviewed the occupational information and summarized it.
Q. So we at least will have something to ask Mr. Fogarty. We'll put that to the side in the file. All right.
But Mr. Fogarty had an opportunity to also review the file and comment on the file. Is that right?
A. On the occupational information.
Q. What did you say Mr. Fogarty is?
A. He's a vocational rehabilitation consultant.
Q. Is he employed by UNUM?

Page 86

A. Yes, he is.
Q. So that UNUM actually employs occupational consultants, doctors?
A. Yes.
Q. And they are utilized in making decisions. Is that right?
A. They're used as a resource.
Q. And this was the first attempt to get in-house people to review his situation?
A. I believe so, yes.
Q. The next document I have is called "research analysis." And I assume what happened is there was a request for some business information. Is that right?
A. Correct.
Q. And there is a packet of material which I have with a clip at the top, which all apparently is part of what you received from that request. Is that right?
A. No. I believe in this clip that I have, there's medical records in here.
Q. Okay.
A. So it may be -- I don't know if it's out of order or.

Page 87

Q. Whatever. In some way or another, you got all this information?
A. Correct.
Q. And these records clearly give you a whole history of Mr. Mazzamuto's medical condition; is that right?
A. I'm not sure. I would have to review all of the records.
Q. Well, I'm going to suggest to you, and we're in a deposition, and if I'm inaccurate. I'm looking at things carrying dates of 2000. I'm looking at things carrying dates of 1997, '96. Just a scan of it would appear that there are documents from '96 through 2000; is that right?
A. Correct.
Q. So you had the benefit of all that information; is that right?
A. Correct.
Q. The next document I'm looking at is also carrying Fogarty's name. I'm going to turn that to the side, too, because otherwise we won't need him to come.
MR. CORRIGAN: Off the record.

Page 88

(Discussion off the record.)
Q. And the next document, is that another Fogarty document?
A. This document.
Q. Goes with the other one?
A. Correct.
Q. I'm going to turn those two to the side.
A. I believe it goes with the first one.
Q. It goes with the first one.
A. I'm not sure as this is all out of order.
Q. Carrying January 31st?
A. Actually it goes with the second.
Q. It goes with the second, because the first is January 22nd.
A. Yes.
Q. Now, we have a new name, Jill Cariglia. Is that who that is?
A. Correct.
Q. Tell me who she is.
A. She is a disability case manager.
Q. And who had brought her into the equation?

A. I did.
Q. What did you want to get from her?
A. Her job is to review medical records once they come in and determine if all pertinent information is in the claim file. And then it would be her job to forward the claim file to our medical consultants for review.
Q. Although I'm going to be asking Fogarty some questions, I think it might be appropriate for us to just go back again. Since you were the claims representative.
Fogarty was giving you his opinion; is that right?
A. I would have to review.
Q. Well, just take a look. Appears to be message of January 22nd, 2001. Date printed of February 2nd of 2001.
A. I don't believe this is an opinion. I believe it's -- he is summarizing the factual information from the claim file.
Q. Now, in his summarizing the factual information from the claims file, does he make any mention of Mr. Mazzamuto's statement "my job requires me to stand most of the time. I am

always stressed, which causes tightness in my chest; then I have chest pain and shortness of breath. Also, by standing, my back problem's aggravated."
Does he mention any of that in his review of the file?
A. I just have to review the document.
Q. Sure.
A. I don't believe he specifically writes that statement. I don't see what you just read to be in this.
Q. And if we take a look at his next. He's saying "after reviewing a recent telephone conversation between CCS" -- Who's that?
A. Me. Stands for customer care specialist.
Q. -- "and the insured." So he had talked to you; right?
A. He reviewed the telephone conversation between Mr. Mazzamuto and I. He reviewed the document.
Q. So he's saying he's prevented from working because of his back. Is that right?
A. He's saying that Mr. Mazzamuto feels

that he is prevented from working by his back.
Q. Yeah. Now, he's saying for the majority of the time, Mr. Mazzamuto indicated he would prepare books and make orders and the like. Now, that's not what he says, though, in that statement, where he says he's on his feet all the time; is that right?
A. Correct.
Q. So, I mean, you had recorded in your January telephone call what you felt should be put into the note. Is that right?
A. I recorded what Mr. Mazzamuto indicated to me.
Q. But it wasn't a taped phone call, was it?
A. No.
Q. We don't know what words he used. We don't know all of what he said. Do we?
A. Not word for word, no.
Q. And, I mean, you'd have to admit that you are employed by UNUM; is that right?
A. Correct.
Q. And your job is to work for UNUM; is that right?

A. Correct.
Q. So that when he's talking about the condition here, he's not saying anything about what Mr. Mazzamuto or what his doctor is saying about how much he has to stand or anxiety or anything like that, is he?
A. Is Jack saying?
Q. Jack's not saying any of that, is he?
A. I don't believe so, no.
Q. And now we're up to Jill. Jack and Jill. What we have is a date of February 22nd. Is that right?
A. Correct.
Q. And Jill says, "this is a 45-year-old male."
MR. ANGINO: Off the record.
(Discussion off the record.)
Q. "45-year-old male with a history of chronic low back pain."
So she's saying, he's got a history of chronic low back pain. Is that right?
A. She's saying that, yes.
Q. She goes through the medical records; is that right?

Page 93

A. Correct.
Q. See, again, this individual does not mention that he's on his feet most of the time, such as what he said in his January report. Is that right?
A. Correct.
Q. So that we now have Jack and Jill both not mentioning that he's on his feet most of the time, at least if you believe what he says in his report. Is that right?
A. I believe they summarize the occupational duties for him as Jill says here. Described his duties as bookkeeping, office duties, employee administration.
Q. The occupational duties form is where he says this, is it not?
MR. HENEFER: You can work off that.
THE WITNESS: Thank you.
Q. I mean right at the bottom of the page there, doesn't he say, "My job requires me to stand most of the time, I'm always stressed which causes tightness in my chest then I have chest pain and shortness of breath. Also, by standing, my back problem is aggravated. I've

Page 94

been under treatment for back pain since 1996"? I mean, if you were going to summarize this report, wouldn't that be part of it?
A. Well, I believe the bookkeeping thing, office duties, and employee administration, I believe that he does not have to stand to perform those duties of his occupation.
Q. Well, what you believe. What did he say?
A. He says he stands. And this information was provided to Jack and Jill.
Q. But neither one mentions that he said that he has to stand most of the time, does it?
A. It does not appear to say that in the review.
Q. It doesn't talk about his being stressed, does it?
A. I don't believe it does.
Q. You'd have to say, therefore, it's selected. They have not summarized this part of it; is that right?
A. That would be an assumption. I don't know why they didn't include that.

Page 95

Q. You don't know why they didn't?
A. Correct.
Q. All she's addressing is the cardiac standpoint. Is that right? "It appears from a cardiac standpoint," is that what she's saying?
A. "It appears from a cardiac standpoint." She does address the back in the first paragraph.
Q. No, no. But in terms of her conclusions in her second paragraph, "based on medical records for review and occupational duties, it is difficult to see how RL applied to insured when it appears that the majority of his occupation does not include heavy lifting or prolonged standing." Is that what she says?
A. Yes, she does .
Q. "Insured's back condition is a chronic condition that he has had for many years and it has not affected his occupational duties yet." Do you see that?
A. Yes.
Q. That's totally incorrect, is it not?
MR. HENEFER: Objection.
A. You'd have to ask Jill.

Page 96

Q. No, no. I mean, we know he was disabled in 1996 from his back problems, did we not?
A. I think the word "disabled" is a broad term. I mean, I believe they paid benefits for a period of time.
Q. They paid benefits in 1996 and 1997 for a back condition; right?
A. Correct.
Q. And it was the same policy that he's making a claim for in the year 2000. Is that right?
A. Correct.
Q. And according to the doctor, his back condition worsened, did it not? According to what he said?
A. Correct.
Q. So that, if she says that it hasn't affected his occupational duties, from what you know, it has. Is that not correct?
A. I believe it did. What you said, it did.
Q. Sure. From the records you had, the back condition had affected his duties; is that

Page 97

correct?
A. Correct.
Q. And she goes on to say, "it appears from a cardiac standpoint, that the insured is stable. And that any chest pains he is having are not cardiac in nature." Is that what she's saying?
A. She does say that.
Q. So if he's getting pain from anxiety, she's not mentioning that; right?
A. She doesn't mention anxiety, no.
Q. Next document, we do have a Bate stamp, 381. Do you see that?
A. Yes.
Q. It's called "Clinical Review Request." So Jill is now requesting a review by whom?
A. She's referring this to Dr. Clarke.
Q. So, we've had two people at this point. And, again, would this be a normal sequence of types of individuals to review something like this?
A. Yes.
Q. And, again, for my clarity, Jill does

Page 98

what type of review?
A. Jill is a disability case manager. She's actually a nurse.
Q. Okay. That's what I was looking for. The types of -- her background is nursing.
A. Correct.
Q. The first individual's background would be?
A. Vocational occupational. Mr. Fogarty you mean?
Q. Yes. Is that what he would be trained in?
A. Correct.
Q. Now we're talking about review by a doctor?
A. Correct.
Q. And would Jill be providing this history?
A. Yes.
Q. Okay. So he does say this man has had chronic low back pain. Is that right?
A. Jill says that, correct.
Q. And that he had a myocardial infarction?

Page 99

A. Correct.
Q. She doesn't say anything about what he does or doesn't do, and doesn't mention anxiety; is that right?
A. She doesn't. But the entire claim file would be referred to Dr. Clarke.
Q. What's the CRS response section, 380, the next document?
A. That's a clinical review specialist. We have nurses that actually review medical records as well.
Q. Is there any -- is this the way it appears, it's blank at the bottom?
A. Yeah, all that -- if a clinical review specialist reviewed it, they would have written a response there. But it's blank.
Q. It's blank. So this is not of any great importance, 380?
A. Correct.
Q. The next we have a letter from Peter Russo dated March 19th. Is that right?
A. That's correct.
Q. And he's wondering why this thing is taking so long. Is that generally what it says?

Page 100

A. Correct.
Q. We then have a letter from you to Russo. Is that right?
A. That's correct.
Q. And you're explaining why it's taking so long; is that right?
A. Correct.
Q. Second to last paragraph, you emphasize that you didn't receive the claim form until December 15th. Is that right?
A. Correct.
Q. And you mention it was approximately five months after his claim date of disability. Is that right?
A. Correct.
Q. "If we had received his claim form within the required time frame, as stated in his policy, 30 days after disability starts or a covered loss occurs, then our evaluation of his claim may not have been delayed."
Were you basically saying here that Mr. Mazzamuto was at fault?
A. No.
Q. What were you saying?

Page 101

A. I was saying that we did not receive his claim form until December 15th, which was approximately five months after his claim date of disability. And that we had received it prior, then it may not have taken so long to complete our evaluation of his claim.
Q. We then have that initial letter that I started this whole process with of March 26th letter. The very first page. Very first page. Just turn the whole thing over.
Again, basically was complaining about the time?
A. Correct. I have that.
Q. We now have the medical review. Is that right?
A. Yes.
Q. And the medical review, we'll be asking Dr. Clarke some questions about that. But from your standpoint what he discusses here is basically -- Strike that.
Dr. Clarke's report expresses an opinion that seems to be limited to his cardiac condition. Does it not?
A. No, I believe he does comment on his

Page 102

back condition.
Q. Well, let's go through the report and get to his opinion, which is, I think towards the end.
MR. ANGINO: This may be a good time. Five after 11. Take a break. Five minutes.
(Recess taken.)
MR. ANGINO: Back on the record.
Q. We were discussing Dr. Clarke's report, which is carrying a date of March 27, 2001. Do you see that there?
A. Right I do.
Q. And he starts off by discussing, "this 45-year-old restaurant owner whose medical records are presented for review." Is that right?
A. Correct.
Q. He does recognize that in the claim progress form dated January 18, '01 Mr. Mazzamuto wrote, quote, "my job requires me to stand most of the time. I am always stressed, which causes tightness in my chest, and then I have chest pain and shortness of breath. Also, by standing, my back problem is

Page 103

aggravated."
So he's only one of these three interviewers to actually recognize and quote Mr. Mazzamuto. Is that right?
A. Correct.
Q. The other ones refer to your telephone interview, but he includes both: the telephone interview and the quote. Is that right?
A. Yes.
Q. He also quotes the attending physician's report of November 15th. Is that right?
A. Yes. Correct.
Q. And he says, "he has symptoms of anxiety, worry, and low back pain." Is that right?
A. Correct.
Q. No prolonged standing. Is that right?
A. With restrictions of no prolonged standing.
Q. So he has a restriction that he shouldn't stand long; is that right?

Page 104

A. He's stating that Dr. Bower said that, correct.
Q. So, if you put the two things in combination, my job requires me to stand most of the time and Dr. Bower saying he shouldn't stand for prolonged time. That would be a restriction; is that right?
A. Correct.
Q. Okay. He also says that he tried to return to work. Is that right?
A. Correct.
Q. But it made his back worse; is that right?
A. He's saying that Dr. Bower wrote that, correct.
Q. And that it had increased the anxiety at work because of the stress. And that he could not return to work at the time related to the restrictions from prolonged standing, heavy lifting, and bending. Is that right?
A. Again, he's saying, yeah, Dr. Bower stated that. Correct.
Q. He's then saying, Dr. Bower on January 18th says he can't return to work

Page 105

because of his back problems. Is that right?
A. That's right.
Q. He then discusses the CAD. Is that right?
A. Correct.
Q. First two paragraphs are with respect to the CAD. And then with respect to his lower back pain, Mr. Mazzamuto has a long history of lower back pain. Is that what he goes through here?
A. Third paragraph after clinical summary?
Q. Yes.
A. Okay, yes, I see that.
Q. And he talks about the medications; is that right?
A. Yes.
Q. Talks about spinal stenosis?
A. Mm-hmm.
Q. CT scan, MRI. Is that right?
A. Yes.
Q. Pain described as burning located centrally in lower back extending down the lateral thighs to the knees. Do you see that?

Page 106

A. Yes.
Q. "Although prolonged standing was said to lead to leg numbness, no abnormality on neurologic exam was reported." Is that right?
A. Correct.
Q. Started bothering him after three hours of standing. Is that right? He reports in office visit?
A. An office visit, correct.
Q. Goes on to say, "his back pain reportedly increased again following hitting a bump during his ambulance ride to the hospital in July 2000. His most recent epidural injections were on October 18 and January 3rd, 2001." Is that right?
A. January 31st, 2001. Correct.
Q. So here's a man, who according to this, has had an increase in his back pain and need for epidural injections in October and January; is that right?
A. That's right.
Q. So in response to questions, he's discussing, with respect to his CAD, then goes on; is that right?

Page 107

A. Correct.
Q. And he says, there's no basis to support a cardiac impairment. Is that right?
A. I'm sorry. Where are you?
Q. "On the basis of the above" -- second paragraph -- "there is no information to support a cardiac impairment which would preclude work involving sedentary to light physical activity." Do you see that?
A. Yes, I do.
Q. "His physician has restricted him from stressful situations, but there does not appear to be any information to support a cardiac impairment related to the stress."
Is he saying the cardiac condition is not physically causing the stress?
A. You would have to ask Dr. Clarke.
Q. Okay. And we will. When you read this, though, how did you read it?
A. I read it as exactly what he said, "there does not appear to be any information to support a present cardiac impairment related to stress, either in terms of a significant stress-induced rhythm disorder or angina."

Page 108

Q. Those are physical things, not emotional things like anxiety; is that right?
A. I believe he's talking --
Q. Physical disability?
A. About his physical cardiac impairment.
Q. Not emotional --
A. I don't see that he says anything about emotional.
Q. Okay. Did you have any part to play in the denial of the disability claim?
A. Yes.
Q. So you were a person who participated in that?
A. Yes.
Q. Did you make the decision, or did you have to get somebody else to agree with your decision?
A. I had my consultant -- she actually signed my denial of benefits letter. But I essentially made the decision working under her, her guidance.
Q. So you were then the person who denied his claim.

Page 109

A. Correct.
Q. So that's why all of this is important. He's saying here, he has no cardiac physical impairment. Is that right?
A. He doesn't use the word "physical."
Q. No, but what he says is physical, is it not? I mean, do you see anything here that talks about impairment because of anxiety?
A. He's not discussing anxiety. He's talking about his cardiac impairment. Cardiovascular.
Q. He then goes on to say, "with respect to his back pain, Mr. Mazzamuto has a long history of lower back pain in association with a degree of spinal stenosis on MRI. In the absence of a radiculopathy on physical exam or other studies, this appears to be soft tissue in origin."
Do you know what soft tissue means?
A. Not, no.
Q. There's bones, then there's nerves, muscles, and tendons. Do you know which is the soft tissue?
A. I would assume it would be muscles.

Page 110

I'm not.
Q. And nerves?
A. Yeah.
Q. Okay. So, you're making a decision to deny this claim, but you don't know what soft tissue is?
A. I don't believe I would need to know what soft tissue is because I'm not a medical doctor.
Q. Okay. He states, "he indicates that the pain is increased with prolonged standing. And his physician has restricted him from prolonged standing."
Is that what he says?
A. Dr. Clarke is stating what the insured indicates, Mr. Mazzamuto.
Q. And what the physician stated?
A. Correct.
Q. Why isn't he disabled if he, Mazzamuto, says pain is increased with prolonged standing, and the physician says he can't stand? Why isn't he disabled?
A. You would have to ask Dr. Clarke.
Q. No, no. I'm asking you. You made

Page 111

the decision to deny his claim.
A. Because I do not feel his occupation required prolonged standing or walking or heavy lifting or bending.
Q. Why?
A. Because he did mostly managerial and administrative duties. And I feel that those could be performed sitting.
Q. Did you ignore what he said? I have to stand all the time, most of the time?
A. I didn't ignore it, but I feel that his -- he could perform the duties of his occupation sitting.
Q. Do you know anything about his work?
A. From what the insured indicated to me, yes, I do. I do know that it was a small restaurant.
Q. Have you ever been to pizza restaurants?
A. I have, yes. We had a field representative visit his restaurant.
Q. We're going to go to that, but, so if the man says to you, that he has to stand most of the time or all the time or whatever he says

Page 112

in his words there, and his doctor says he can't do that, you as a claims representative, don't you have to take that into account?
A. Yes, we take everything into consideration.
Q. Are you aware from anything that has been told to you by your education, training, supervisors, teachers that you have to give the insured the same benefit as you do your employer? Have you been told that by anybody?
A. As your employer? I'm confused by the question.
Q. Well, you're employed by UNUM; is that right?
A. Correct.
Q. But you have insureds who basically pay premiums. Is that right?
A. Correct.
Q. So, in terms of treatment, you have to treat them as equal. Is that correct?
A. Correct.
Q. That's what I'm saying. He goes on, Dr. Clarke, to say, "his job does not appear to involve heavy lifting." Is that right?

Page 113

A. Correct.
Q. "The degree to which he is required to stand or walk for prolonged uninterrupted periods of time over 15 to 20 minutes at a time is not clear." Is that what he says?
A. He does say that.
Q. But, earlier on, he did quote by saying, "my job requires me to stand most of the time." Is that right?
A. Correct.
Q. So he had that information; is that right?
A. Correct.
Q. "It should also be noted that lower back pain tends to wax and wane." Do you know what that means?
A. Come and go.
Q. "And also he appears to have had prolonged exacerbations after episodes of trauma, slipping on ice and a bump during the ambulance ride, the discomfort has subsided in the past."
So he's saying that the back pain subsided enough from his 1996 episode that he

Page 114

was then able to go back to work in 1997. Is that right?
A. I'm not sure of the exact dates, but he is -- the first part of what you said is correct. That it --
Q. At least enough to return to work.
A. Return to work, correct. I'm not sure of the exact date he went back to work, but, correct.
Q. But, there's no indication that he did go back to work after this episode of back pain. Is that right?
A. I don't know if he went back to work.
Q. But, I mean, you have no evidence that he went back to work?
A. Correct.
Q. Next document, which is 3/28, can you tell me what that is, carrying the Bate stamp of 377.
A. This is a management referral completed by my consultant.
Q. Whose name is?
A. Diane Cahill.
Q. I'm going to just read it for the

Page 115

record and we can go from there.
"Please complete the action plan and log."
Isn't that something that we had seen earlier, back in January, an action plan or something?
A. Yes.
Q. And what had not been completed in the action plan that you had to complete?
A. I believe she was referring to the log. The action plan was completed because she signed it on January 8th. But the log is the chronological order of what was happening in the claim file.
Q. You hadn't done that?
A. I must not have had it -- I don't know if it was fully completed, partially completed, I'm not sure.
Q. Do we have any evidence that it had even been started?
A. I'm not sure.
Q. Normally with handling a file from a claims department, don't you have to follow a sequence of time in what you're doing at

Page 116

different times? Isn't that the normal procedure?
A. Well, the normal procedure would be to complete the action log.
Q. She goes on to say, "according to the restrictions and limitations placed on Mr. Mazzamuto, and his occupational description, I'm not clear as to why he is unable to return to work. While we await the medical records."
This doesn't seem to make any sense. You had the medical records by March 28th?
A. Yes. I believe what happened was the medical records were with Jill Cariglia, the clinical review specialist. And Diane was not aware that they were in Jill's possession.
Q. I was going to say, certainly by March 28th, you had all the medical records that you wanted; right?
A. Correct.
Q. Okay. "A field visit might help clear up what Mr. Mazzamuto considers his restrictions and limitations. We should also advise" -- who's this?
A. Advise him.

Page 117

Q. -- "that we are having some difficulty getting the records."
You weren't having any difficulty getting the records; right?
A. At first we were. And I believe that this document is actually dated --
Q. March 28?
A. -- February 28th. I believe she changed it to a two.
Q. Oh, really. Okay.
A. But at this point, we did have the medical records.
Q. What's her position in relation to you?
A. She's my consultant.
Q. A consultant. Tell me what a consultant is.
A. She's a resource.
Q. She's not your superior?
A. I have a consultant who I directly report to. And then above her I have a manager or a director.
Q. But they're both superior to you?
A. Correct.

Page 118

Q. So your consultant is your intermediate supervisor?
A. Correct.
Q. I'm just trying to get the chain of command. Okay.
The next thing I see is March 28th. Looks like a claim form memo, person calling attorney. Do you see that?
A. Yes.
Q. 3/28. I don't have a Bate stamp number for that. Says, "called attorney, read him medical evaluation over the phone. He feels" -- What is that: "I OCC"?
A. It's insured. Means insured.
Q. -- "insured's occupation is stated wrong. Well that's how I wrote it." What does that mean?
A. "Insured wrote it."
Q. "Insured wrote it. He said he is only one of two cooks and does everything in the restaurant. I said he didn't indicate that. He said he thought this application indicates that when they completed app, he thought it was more extensive. No" -- What's that?

Page 119

A. "No, I looked at application." I must have looked at the application while on the phone with him.
Q. Who completed the application?
A. I would have to look at the application.
Q. Well, you know from the record, it says the agent, it was his handwriting, do you not?
A. Again, I would have to review the application. I don't remember.
Q. Well, it was done in terms of his earlier claim for disability in 1996, one of the things they were concerned at that time was whose handwriting was the application. And don't you remember that the claimant was asked to answer certain questions. And one of which was, who filled out the application, he said he didn't. Do you dispute that?
A. I remember the questionnaire, I don't remember the exact questions.
Q. So, an agent is filling out an application to get business. Is that right?
A. He's filling out an application so

Page 120

the insured can get disability coverage.
Q. And he's to get a premium; right?
A. I'm not sure how that works.
Q. You're not sure that people who write policies get paid?
A. No, I'm sure that they get paid. I don't know how the financial aspect works.
Q. But I'm saying if the person doesn't get the insurance, the agent doesn't get paid; right?
A. That would be an assumption. I'm not sure if they have salary. I don't know.
Q. Well, you remember from the application it says "first-class restaurant"; is that right?
A. I don't remember. Again, I'd have to review the application.
MR. HENEFER: That phone memo is 371.
Q. We then have the field report; is that right?
A. Correct.
Q. And this individual's assigned to do this field report on January 16th; is that right?

A. Correct.
Q. And it has a Bate stamp of 376.
A. Yes.
Q. And I'm glad you're giving me complete copy, because some of this is blocked out, where I can't read parts of this report.
But although he was assigned to go out to do this report on January 16th, it indicates he didn't do it until April 4th. Is that right?
A. Correct.
Q. Do you know why February, March, and April -- two and a half months went by to do this?
A. I don't know.
Q. From my involvement in other insurance cases, when assignments are made for field reports, aren't they supposed to be done within 30 days or less?
A. In my actual referral, there's a box, and I had checked off 30 days, but I believe, and I'm not a hundred percent positive, that this may have taken a little bit longer because we had also asked him to go out to the restaurant as well as meet the insured.

Q. So your box has the 30 days that I've mentioned; is that right?
A. Correct.
Q. Are there earlier times that you can mark off, sooner?
A. 15.
Q. 15, 30. Is there any other time period?
A. 60.
Q. Any other time?
A. I don't believe so. I'd have to look at the form.
Q. So, again, I assume we'll get a Bate stamp form for that. I didn't see anything there as far as the request for it. But I just knew from other things that there are these numbers that appear. And there's no number that appears beyond 60 days, is there?
A. No.
Q. So, April 4th would be two and a half months, which if we do the arithmetic will be 75 days; is that right?
A. Approximately correct.
Q. So, this particular customer who

first made a verbal notice potentially in July, certainly in September, we have -- you definitely getting the records on December 15th. You're doing certain things on January 15th. We now have until April 4th, until we're getting a field report. Is that the history so far?
A. Correct.
Q. Correct. That he's interviewing this individual in his home. Is that right?
A. Correct.
Q. Do you know the time of day that he's interviewing him?
A. I do not believe he indicates the time of day.
Q. Whatever it is, the man isn't at work; is that right?
A. Correct. He's at home.
Q. He's describing the man by his height and approximate weight, how he's dressed, things like that. Is that right?
A. Correct.
Q. He's describing somebody whom as he escorts this agent, or escorts this field representative, he's observing limping. Is that

right?
A. Correct.
Q. Favoring his right leg; is that right?
A. Correct.
Q. He's also hunched forward slightly; is that right?
A. Correct.
Q. "During the interview, he stated he gets out of breath quite frequently, but he was able to talk at length without gasping for air." Is that right?
A. Correct.
Q. So the man can talk, is that right, according to this?
A. According to what Mr. Coar says, correct.
Q. Interview's conducted at the kitchen table; is that right?
A. Yes.
Q. During that time, the insured's seated. Is that right?
A. Yes.
Q. Interview of approximately one hour,

Page 125

20 minutes. Is that right?
A. Yes.
Q. He notices that while the insured is seated, he has the majority of his weight on his left side. Is that right?
A. Yes.
Q. "Pleasant, cooperative, and did answer my questions fully." Is that what he says?
A. He does.
Q. Goes through the medical; is that right?
A. Mm-hmm. Yes.
Q. Says that insured is seeing two physicians; is that right?
A. Yes, he does.
Q. Mentions prescriptions that he's taking; is that right?
A. Correct.
Q. Says there's two reasons why he can't go back to work; is that right?
A. That's correct.
Q. "First and foremost is that with his heart, he has shortness of breath and has to

Page 126

catch his breath quite frequently." Is that what he says?
A. He does.
Q. "Doesn't have any pain in his heart or back anymore, but the shortness of breath concerns him." Is that what he says?
A. He does.
Q. Goes on to say that his father had a stroke and three heart attacks and it killed him; is that right?
A. That's right.
Q. He's afraid that he might have one and die; is that right?
A. That's right.
Q. "While working at the business, he gets nervous and sometimes loses his temper"; is that right?
A. That's right.
Q. "He's afraid if that happens, he may have another heart attack"; is that right?
A. Correct.
Q. "Secondly, he stated that when he was put in the ambulance when he had his heart attack and was transported to hospital, he

Page 127

re-injured his back"; is that right?
A. Mm-hmm. Yes.
Q. "Claims that his back is as bad now as it was in 1996," is that what he says?
A. Yes, he does.
Q. So he's telling this representative, I was disabled in 1996, my back was bad then, I'm just as bad now. Is that right?
A. No, he doesn't say he was disabled. He just stated that his back was as bad now as it was in 1996.
Q. I added that --
A. Right.
Q. -- you know, as literary, but he was disabled in 1996. At least you paid for it; right? New York Life paid a period of benefits, correct, back in 1996?
A. Correct.
Q. And he's saying his back is as bad as it was then?
A. He is saying that.
Q. I'm just as a lawyer saying if his back is as bad at the time of this interview as it was in 1996, and New York paid in 1996, can

Page 128

you tell me why you didn't pay in 2001?
A. He did return to work sometime around, I don't know if it was 1996 or 197. But after forwarding all information to our medical consultants, we determined that he was ineligible for total disability benefits.
Q. In 2001?
A. Correct.
Q. But, can you give me the logical reason that if somebody is as bad in 2000, 2001, just from the back, as he was in 1996, and if the medical records show that his condition worsened, at least from Dr. Bower, why you would pay in 1996 and not pay in 2000?
MR. HENEFER: Objection to the form. You can answer.
A. There's kind of a lot of questions there. Can you rephrase the question?
Q. Sure. It's one question.
A. Okay. It was long, so I forgot the first part of it.
Q. Sure. Assuming that this record, the papers that we've gone through today, the papers you had available to you, show, one, that he had

Page 129

a back condition in 1996; that you paid, or New York paid for that back condition in 1996. His back condition is at least as bad, if not worse in the year 2000, 2001, and you don't pay. Can you tell me why?

MR. HENEFER: Objection to the form. But you can answer.

A. I do not believe the medical records supported that his back was worse or as bad as it was in 1996. I believe it may have been the same. But upon review of the restrictions and limitations that Dr. Bower placed on the insured, we did not feel that those restrictions and limitations would prevent him from performing the duties of his occupation.

Q. Weren't those restrictions and limitations the same in 1996 as they were in 2000?

A. I'm not sure. I would have to look at --

Q. Wasn't his job the same in 1996 as it was in 2000?

A. His job was, correct.

Q. So if his job was virtually the same.

Page 130

So if his back were even just the same --

A. He did return to work in, sometime in 1996 or 1997. We did not see a change in his back condition that would have prevented him from returning to work. He was working then, we didn't see why he wasn't able to work in 2001 with that same back condition.

Q. Are you saying, therefore, that you didn't see any exacerbation?

A. I did see that Mr. Mazzamuto stated that the ambulance ride exasperated (sic) his back condition. But, after review of Dr. Clarke's medical review, that's what we based our determination on that we did not feel he was eligible for total disability benefits.

Q. Well, I'm not going to argue with you on the point of Dr. Clarke's record, but Dr. Clarke does not address that he's not disabled as far as a back condition goes.

Show me where he does?

A. Dr. Clarke would not indicate, in his review that he is not disabled. That would be my determination. However, Dr. Clarke -- excuse me, Dr. Clarke does indicate that "there does

Page 131

not appear to have been any significant structural change in his condition associated with the recent exasperation (sic)." He also indicated that his discomfort has subsided in the past, at least enough to return to work.

Q. But it didn't say it subsided this time, did he? Does he say that it subsided this time?

A. No. But he says, there does not appear to have been any significant structural change in his condition associated with the recent exacerbation. So my understanding of that statement is there doesn't appear to have been a change from 1996 to --

Q. Do you know what the word "structural" means?

A. I'm not exactly sure how to define it, but.

Q. Structural. For instance, if you've got stenosis, if you've got arthritis. A structural change would be a worsening in what you can see in the structure. Would you accept that?

A. Yes.

Page 132

Q. Okay. All he's telling you is that structurally there hasn't been a change. But doesn't he say his problems are not structural, they're soft tissue, is that not what he says?

A. He does say this appears to be soft tissue in origin with regards to the spinal stenosis.

Q. So, soft tissue is not structural; is that right? You don't see soft tissue on an x-ray, do you?

A. I don't believe so. I'm not a hundred percent positive.

Q. So whether there's a structural change or not a change, should that have any meaning? If your injury is soft tissue.

A. Could you rephrase the question?

Q. If your injury is soft tissue, whether your structure changes or not is irrelevant, is it not?

MR. HENEFER: Objection to the form. You can answer.

A. Dr. Clarke states that, he doesn't state about it being an injury. He just indicates that something is soft tissue in

Page 133

origin. He doesn't indicate how that would prevent him from performing the duties of his occupation, or if it's limiting him at all.
Q. Let me just perhaps give you a for instance.
A. Okay.
Q. If a nerve in your body is damaged, you could take an x-ray and it wouldn't show it. Is that right?
A. I believe so, correct.
Q. But, you still could be disabled from that nerve being damaged; is that right?
A. Hypothetically speaking.
Q. And muscles can be damaged, and ligaments can be damaged. Is that right?
A. Correct.
Q. And those muscles and ligaments and nerves by being damaged, can disable you, can they not?
A. They could.
Q. Even though the structure stays the same; is that right?
A. Again, hypothetically speaking, it could.

Page 134

Q. Where do you say, therefore, a basis for you to deny his claim?
MR. HENEFER: Objection.
Q. In Dr. Clarke's report. In Dr. Clarke's report.
MR. HENEFER: Note an objection to the form of the question. But you can answer.
A. I believe that, again, based on the duties of his occupation, and based on the restrictions and limitations that Dr. Bower placed on Mr. Mazzamuto, I believe that he could perform the duties of his occupation perhaps with accommodations, he could sit performing the duties.
Q. If his job requires him to stand most of the time, and the doctor says he's restricted from any prolonged standing, more than 15 or 20 minutes at a time, is it not disabled?
MR. HENEFER: Note an objection to the form of the question, but you can answer.
A. I don't recall the physician saying that he couldn't stand for more than 15 to 20 minutes.
Q. Isn't that what Dr. Clarke talks

Page 135

about, 15 to 20 minutes? Last paragraph.
A. He doesn't indicate who says that. He just says, "the degree to which he's required to stand or walk for prolonged uninterrupted periods of time over 15 to 20 minutes at a time is not clear."
I believe that the insured may have stated this, that after 15 to 20 minutes he experiences pain. But I don't believe a physician said that.
Q. Well, if you have to -- job requires you to stand most of the time, that would make you disabled if you start to get pain after 15 to 20 minutes, would it not?
A. Again, I don't believe that his job required him to stand most of the time.
Q. You know what's so incredible, to me, just as a lawyer, how do you know what his job required?
MR. HENEFER: Objection to the form. You can answer.
Q. Please answer that. How do you know what his job required?
A. The insured indicated that, what his

Page 136

duties of his occupation are, and those duties, I believe, could be performed sitting. I don't believe that he does bookkeeping standing or administrative duties standing.
Q. You don't believe him when he says he has to stand most of the time, do you?
A. He may have stood most of the time, but, again, I believe he could perform those duties sitting. I don't see why he couldn't.
Q. What was told in Dr. Bower's deposition is that whenever Dr. Bower has gone to this pizza restaurant, he was able to observe what Mr. Mazzamuto does. Supposedly, at his restaurant, there is what I will almost call like a counter where he sees Mr. Mazzamuto, or had seen Mr. Mazzamuto most of the time. And the height of that counter is such that you can't sit. Did you know that is where he generally worked?
A. No, I did not.
Q. So, that if you work at this counter that is a high counter, and people come in, and you have to stand at this counter, if you have to have a register where you basically collect

Page 137

their money, if you have to stand at that counter and greet the people, and say thank you for coming, you can't sit. Do you understand that?

MR. HENEFER: Objection to the form of the question. You can answer if you're able.

Q. Do you understand that?

A. Again, I believe with accommodations he could perform the duties of his occupation.

Q. How can you greet guests behind a counter, take money from behind a counter, observe what's happening and supervise employees from behind a counter that is too high to sit?

MR. HENEFER: Objection to the form of the question.

Q. Tell me how you could do that.

THE WITNESS: Do you want me to answer?

MR. HENEFER: If you're able to answer.

A. I don't -- first of all, I don't believe that he took money. I don't recall that being a duty of his occupation. But, I believe that he could -- he could sit with

Page 138

accommodations. He wouldn't have to sit behind a counter.

Q. Don't you realize that you made a decision that he wasn't disabled without knowing what this place looked like? That there was a counter that he stood behind. Did you know that up until this moment?

A. No, I did not.

Q. So you turned down this man, and he has not been able to collect any disability insurance, for which he paid, for almost two years without you're even knowing where he had to stand. Is that right?

MR. HENEFER: Objection to the form of the question but you can answer.

Q. Is that not correct?

A. Correct.

MR. HENEFER: Off the record.

(Discussion off the record.)

Q. Take a few more minutes to go through the field report, 15 minutes with Mr. Fogarty, 5 or 10 minutes with Dr. Clarke, and then he'll be done.

A. Okay.

Page 139

Q. He described his back condition, is that right? Second page.

A. Are you referring to the field report?

Q. Field report. I think it's the third page. Out of work for about a year. Do you see that? First full paragraph?

A. Correct.

Q. Walks with a limp. Do you see that again?

A. That the insured states, yes, I see that.

Q. Do you think this man is a malingerer, that he's putting this limp on for benefit of your field representative?

A. I don't believe I can answer that question.

Q. And when he sits, can't put pressure on his right side. Do you see that?

A. Yes, I do.

Q. Pain starts in his back and runs down to his right leg. Do you see that?

A. I see that the insured stated that about his pain, yes.

Page 140

Q. Did you ever send him to some doctor to have him examined?

A. No, we did not.

Q. So you don't have any doctor that's ever examined this man. Is that right?

A. Correct.

Q. So you denied his claim without even having him examined. Is that right?

A. Correct.

Q. Says he has numbness in his right leg. Is that right?

A. Yes, correct.

Q. Can't bend. If he drops something on the floor, needs to pick it up. Do you see that?

A. I do.

Q. When he sleeps, he sleeps on his stomach with pillows under his stomach, ankle, and head. Do you see that?

A. Yes, I do.

Q. As far as sitting, standing or walking, he stated he can only do these activities for about 20 or 30 minutes before changing positions. Do you see that?

A. Yes, I do.
Q. Goes on to describe his activities. Is that right?
A. His current activities.
Q. Do you see anything in here where the man went to the restaurant and described that there's a counter, the man would stand behind the counter, what he would do behind the counter, what his activities would be. Do you see any of that?
A. Well, the part about him going to the restaurant is actually cut off, so I don't --.
"After I met with the insured I went to the business. The business is pretty much a pizza restaurant with some articles on the menu. The restaurant has about 15 tables in the establishment and when I went there during lunch hour about half of the tables are taken. There were three young -- there were three workers at the business. One older female, who is probably the insured's wife and two younger males, probably the insured's son. Shortly after, I departed the area."
Q. No mention of the counter, no mention

of people standing behind the counter, how high the counter was, where the register is, none of that. Is that right?
A. Correct.
MR. ANGINO: I have no further questions.
MR. HENEFER: I'm going to reserve my questions until the time of trial with this witness.
(At 11:54 a.m., the deposition then ended.)

COMMONWEALTH OF MASSACHUSETTS
WORCESTER, SS.

I, Dianne G. Rutan, a notary public in and for the Commonwealth of Massachusetts, do certify that pursuant to appropriate notice of taking deposition, there came before me the subject deponent, who was by me duly sworn; that said witness was thereupon examined under oath and said examination reduced to writing by me; and that the deposition is a true record of the testimony given by the witness.

I further certify that I am not a relative or employee or counsel or attorney for any of the parties, or a relative or employee of such counsel or attorney, nor am I financially or otherwise interested in the outcome of the action.

Witness my hand and official seal at Worcester, Massachusetts, this 23rd day of April, 2002.

My Commission Expires
June 5, 2003

_____
Notary Public

The foregoing certification of this transcript does not apply to any reproduction of the same in any respect unless under the direct

I have read the foregoing, and it is a true transcript of the testimony given by me at the taking of the subject deposition.

_____
MELISSA MULRY

_____
DATE

DR-0423mm

ERRATA SHEET

I WISH TO MAKE THE FOLLOWING CHANGES IN THE FOREGOING TRANSCRIPT OF MY DEPOSITION:

PAGE	LINE	CHANGE	REASON

DATE: _____

_____
MELISSA MULRY

DR-0423mm

-D-

-S-

-T-

-U-

Peter J. Russo
ATTORNEY AT LAW

5010 East Trindle Road, Suite 200
Mechanicsburg, PA 17050

Offices in Carlisle, PA

PHONE: (717) 591-1755
FAX: (717) 591-1756

Monday, March 26, 2001

Melissa Magner
The New York Life Insurance Company
UNUMProvident Corporation
18 Chestnut Street
Worcester, Massachusetts 01608-1528

VIA TELECOPIER & US MAIL
508-751-7430

RE: **VINCENZO MAZZAMUTO**
Claim# 13-H3236167-002

Dear Ms. Manger:

My client has again asked me to take some action in attempting to obtain an answer from UNUM regarding his claim. To that end, we were expecting that your medical staff would have the opportunity to review the claim information toward the end of last week. As my client nor I have received a determination from UNUM, he asked that I inquire when your evaluation might be completed and how long thereafter would a determination follow.

My client and I do not mean to be difficult in this matter but several years ago he reduced the waiting period on the policy from 6 months to 3 months as being without income for the 6 months was deemed too detrimental. Unfortunately, in July you were provided verbal notice of the claim and we continue to wait for a determination. Even if you calculate from the time you received the paper claim in December, three months have already passed. Please assist us in any way possible.

Very truly yours,

Peter J. Russo

PJR/mmm
cc: Vincenzo Mazzamuto

5-19-97

Initial Set-Up Form - New Claimant

Person Calling: **Ms. Mazcamuto**

Relationship to Insured: **Wife**

Telephone # of Person Calling: **717-243-0383**

Name of Insured:	**Vincenzo Mazcamuto**	Title	
Address (Street):	**501 Limestone Rd.**	Home Phone:	**717-243-0383**
City, State, ZIP	**Carlisle, PA 17013**	Business Phone:	
Date of Birth:	**5/25/55**	Policy No(s):	**H3236167-NYL**
Social Security Number:	**196-56-5744**	Previous Claim?	**Unknow**
		If so, when?	

Nature of Disability: **heart attack**

If Pregnant, Due Date:

Date of Disability	First Date Treated	Last Date Worked
7/22/00	**7/22/00**	**?**

Insured's Occupation: **Restaurant Owner** Self-Employed? **Yes**

Employer of Claimant's Business Address: **Vinnys Rest Inc.?**

Type of Claim/Coverage

- [X] TD Sick
- [ ] RD Sick
- [ ] TD Acc
- [ ] RD Acc
- [ ] NDI
- [ ] RR
- [ ] VB
- [ ] Cancer
- [ ] Mammogram
- [ ] BOE/DI
- [ ] BOE only

Line of Business

- [ ] PLA
- [ ] PLC
- [ ] Paul Revere
- [ ] TNE
- [ ] Equitable (to Springfield)
- [ ] John Hancock
- [ ] Provident Mutual
- [ ] MPA
- [ ] NorthWest
- [ ] Great West
- [ ] General American
- [X] New York Life

Notes:

Recorded by: **Diann Jarvis**

Date: **09/06/2000 09:02:27 AM**

NYLCL00557

Initial Set-Up Form - New Claimant

Person Calling:

Relationship to Insured: **Wife**

Telephone # of Person Calling:

Name of Insured:	**Vincenzo Mazzamuto**	Title	
Address (Street):	**501 Limestone Rd.**	Home Phone:	
City, State, ZIP	**Carlisle, PA 17013**	Business Phone:	
Date of Birth:	**5/25/55**	Policy No(s):	**13-H3236167**
Social Security Number:	**196-56-5744**	Previous Claim?	**Yes**
		If so, when?	**1996**

Nature of Disability: **General**

If Pregnant, Due Date: **N/A**

Date of Disability	First Date Treated	Last Date Worked
Unknown	**Unknown**	**Unknown**

Insured's Occupation: Self-Employed? **No**

Employer of Claimant's Business Address:

Type of Claim/Coverage

- ☒ TD Sick
- ☐ RD Sick
- ☐ TD Acc
- ☐ RD Acc
- ☐ NDI
- ☐ RR
- ☐ VB
- ☐ Cancer
- ☐ Mammogram
- ☐ BOE/DI
- ☐ BOE only

Line of Business

- ☐ PLA
- ☐ PLC
- ☐ Paul Revere
- ☐ TNE
- ☐ John Hancock
- ☐ Provident Mutual
- ☐ MPA
- ☐ NorthWest
- ☐ Great West
- ☐ General American
- ☒ New York Life

Notes: New York Life

Recorded by: **Kimberly Barbee**

Date: **09/27/2000 01:09:07 PM**

NYLCL00556

MAZCAMUTO
13H323667-002

LAST NAME: MAZCAMUTO

FIRST NAME: VINCENZO

TERRITORY	POL PLAN	ISSUE DATE	FICA Yes ☐ No ☐
	9132	8-28-93	
	D.O.B	COLL. PT.	AGENT #
	5-25-55	401	99999

DISABILITY DATE 7/22/00

CLAIMANT

HOME PHONE #

BUSINESS PHONE #

OTHER CLAIMS

CLOSE DATE	REOPEN DATE	EP USED TO DATE	PREMIUM WAIVER DATES			EXAMINER ACTION LOG	
			PREMIUM MODE: ______			ACTION	DATE
			TYPE	FROM	TO	assigned	10/10/2000 [illegible]

	REFERRED	OPEN	HANDLED
REHABILITATION	☐	☐	☐
SPECIAL SERVICES	☐	☐	☐
INQUIRIES	CIB	DIR	FICA

LIFE # ______
REFER TO 799-99 AT 3 MOS
☐ NO LIFE WAIVER ☐ HAS LIFE WAIVER REFER WHEN CLM ENDS

NEW NOTICE CALL	4 MOS.	18 MOS.
90 DAY CALL	8 MOS.	

HEALTH CHANGE	APPROVED BY	CODED BY	HEALTH CHANGE	APPROVED BY	CODED BY
DEAD			AGE TERM.		
RESCISSION					
LHOC/LHOS					

13H323667-002

NYLCL00563

FORM 6602 (Rev. 4/96)

October 11, 2000

Vincenzo Mazcamuto
501 Limestone Road
Carlisle, PA 17013

Re: Claim # 13-h3236167-002

Dear Mr. Mazcamuto:

We are writing to confirm the receipt of your claim materials. The claim representative who will be handling your file is Melissa A. Magner. Please be assured that we are giving your file our attention and your representative will be in contact with you in the near future.

Should you have any questions or concerns, you can reach your representative at 1-888-226-7959, extension 6710.

Customer Care Center
The Paul Revere Life Insurance Company

Michelle Bachini

10/19/2000 09:16:23 AM

Sent by: Michele Bachini

To: Kristin Hyland/Provident Life/US, Nicole Hoyt/Provident Life/US, Linda Downing/Provident Life/US, Sue Williams/Provident Life/US, Melissa Magner/Provident Life/US, Diane Cahill/Provident Life/US, Diane Freeman/Provident Life/US, Tricia Moynihan/Provident Life/US, Janet Burns/Provident Life/US, Tracy McLaughlin/Provident Life/US, Melissa Depanian/Provident Life/US, Melissa Kirby/Provident Life/US,

cc:

Subject: lost apps

THE FOLLOWING APPS COULD NOT BE FOUND DOWNSTAIRS IN THE APP VAULT. I WILL ASK NYL IF THEY HAVE A SACN, BUT IF THEY DID THEY WOULD HAVE SENT IT TO US.....BUT I WILL TRY ANYWAY:

Nomejko, H2285809
Huddleston, H3145667
Phipps, H2359286
Toig, h3042942 & H6000491
Prellwitz, H3173680
Gorman, H3250340
Mazcamuto, H3236167
Mondolo, H2358514
Wyly, H2734072
Stone, H3171150
Niles, H2190478
Rees, H3117334
Rutland, H2425513
Daniel, H3168381
Molinaros, h3262696
Flately, H2353580
Wolff, H3230077

I had app files do two misfiles on each of these and they could not be found. I will let you know what I hear from NYL.

Michele.

Michelle Bachini

10/19/2000 09:28:08 AM

Sent by: Michele Bachini

To: Anetta_Ingram@newyorklife.com
cc:
Subject: lost apps

The following list is more apps we cannot find and we are hoping you have scans available. These are all supposed to be on our Image mainframe, but only the policy info has been entered, nothing else. Do you have scans for these? Please let me know.
Thank you. Michele.

---------- Forwarded by Michele Bachini/Provident Life/US on 10/19/2000 09:16 AM ----------

Michelle Bachini

10/19/2000 09:22:17 AM

Sent by: Michele Bachini

To: Kristin Hyland/Provident Life/US@Unum, Nicole Hoyt/Provident Life/US@Unum, Linda Downing/Provident Life/US@Unum, Sue Williams/Provident Life/US@Unum, Melissa Magner/Provident Life/US@Unum, Diane Cahill/Provident Life/US@Unum, Diane Freeman/Provident Life/US@Unum, Tricia Moynihan/Provident Life/US@Unum, Janet Bums/Provident Life/US@Unum, Tracy McLaughlin/Provident Life/US@Unum, Melissa Depanian/Provident Life/US@Unum, Melissa Kirby/Provident Life/US@Unum
cc:
Subject: lost apps

THE FOLLOWING APPS COULD NOT BE FOUND DOWNSTAIRS IN THE APP VAULT. I WILL ASK NYL IF THEY HAVE A SACN, BUT IF THEY DID THEY WOULD HAVE SENT IT TO US.....BUT I WILL TRY ANYWAY:

Nomejko, H2285809
Huddleston, H3145667
Phipps, H2359286
Toig, h3042942 & H6000491
Prellwitz, H3173680
Gorman, H3250340
Mazcamuto, H3236167
Mondolo, H2358514
Wyly, H2734072
Stone, H3171150
Niles, H2190478
Rees, H3117334
Rutland, H2425513
Daniel, H3168381
Molinaros, h3262696
Flately, H2353580
Wolff, H3230077

I had app files do two misfiles on each of these and they could not be found. I will let you know what I hear

MASLAND ASSOCIATES, INC.
INTERNAL MEDICINE

MEDICAL ARTS BUILDING 220 WILSON STREET, CARLISLE, PA 17013 (717) 249-1929 Fax (717) 249-9332

DAVID S. MASLAND, M.D.
RETIRED

JOSEPH F. BRAZEL, M.D.
INTERNAL MEDICINE

FRANK P. CASTRINA, M.D.
PULMONARY

LARRY S. RANKIN, M.D., F.A.C.C.
CARDIOLOGY

DEBRA D. TAYLOR, M.D.
INTERNAL MEDICINE

LESTER L. HIMMELREICH, III, M.D., F.A.C.P.
INTERNAL MEDICINE

MICHELLE M. HALE, M.S.N., C.R.N.P.

TERRY A. ROBISON, D.O.
INTERNAL MEDICINE

PHILIP A. NEIDERER, D.O.
INTERNAL MEDICINE

DOUGLAS J. BOWER, M.D.
INTERNAL MEDICINE

November 3, 2000

Paul Revere Life Insurance Company
New York Life Customer Care Center
P.O. Box 15001
Worcester, MA 01615-0001

New York Life Insurance Company
51 Madison Avenue
New York, New York 10010

RE: Vincenzo Mazzamuto
DOB: 5/25/55

Dear Sir or Madam:

I am writing this letter to clarify the medical facts of my patient, Vincenzo Mazzamuto, who apparently has policies with your companies. I find it difficult to coherently fill out the forms as his medical problems are several, some of which are long standing and do not easily fit into a category such as "when did symptoms appear". Mr. Mazzamuto has had a long history of low back pain and in fact for many years has undergone numerous treatments and physical therapy and MRI in the past did reveal central spinal stenosis which gradually worsened to a maximum at the L3-L4 level and extends from L2 to L5. This has given him periodic problems with lower back discomfort, symptoms of radiculopathy and urinary irritability. Prolonged standing and heavy lifting have aggravated it. He has been seen in physical therapy, treated in a local Pain Clinic with local injections as well as prescription analgesics, nonsteroidal anti-inflammatory agents and other atypical chronic pain medications.

Mr. Mazzamuto's condition was complicated this year when he was admitted to the hospital on July 22nd with new onset angina and a small subendocardial myocardial infarction. He underwent cardiac catheterization and had a subsequent PTCA of a distal LAD stenosis. He is currentlyinvolved in cardiac rehabilitation.

The patient did subsequently have one re-admission to the hospital with chest pain after his initial admission where this pain was subsequently felt to be noncardiac in nature.

As the patient has attempted to return to work after his recovery from his heart attack, his back has worsened again, also the stress and anxiety which has been provoked because of his recent cardiac problems, and manifested themselves with significant anxiety when he is back in a work situation.

While his heart condition has currently stabilized and should hopefully not pose a great limitation on him in the future (assuming ongoing risk factor modification is successful such as smoking cessation, cholesterol lowering, etc), the amount of weight he has gained from his smoking cessation has re-exacerbated his chronic and progressive back problem. At the present time he is not able to do the work required in running his restaurant because he cannot stand for a prolonged period of time, has difficulty bending, and is restricted from heavy lifting. It is unlikely he will be able to return to work in the foreseeable future.

His prognosis for recovery is fair over the next 6 to 12-months.

At his last visit on October 4th he weighed 206 lbs., his blood pressure was 112/80, his pulse 48 and regular. He was proceeding with his cardiac rehabilitation program and was to follow-up with the Pain Clinic for further symptomatic treatment of his back. At the present time the patient has not achieved a medical plateau. It is my hope that once his weight stabilizes after his smoking cessation is consolidated and he completes his cardiac rehabilitation he may be able to attempt weight loss and hopefully improve his back situation in the future.

The final results of this may not be evident, however, for the next 6-months.

If further information is required in order to complete your evaluation, please do not hesitate to call our office. I hope that this narrative summary provides you with the information you need and you can extract those pertinent pieces which you find relevant to insert into your form.

Thank you for your consideration in this matter.

Sincerely,

Douglas J. Bower, M.D.

DJB/gav
T: 11/7/00

FORM 1

NEW YORK LIFE INSURANCE COMPANY 51 Madison Avenue, New York, N.Y. 10010
NEW YORK LIFE INSURANCE AND ANNUITY CORP. (A Delaware Corporation)
NYLIFE INSURANCE COMPANY OF ARIZONA (Not Licensed in Every State)

INSURED'S APPLICATION FOR DISABILITY BENEFITS

368799

TO ENABLE US TO EXPEDITE CONSIDERATION OF YOUR CLAIM: Please fully and completely answer each question, sign and date all forms and attachments and return the originals to us. Failure to complete all questions or to sign and date the claim form(s) or authorization will result in a delay in the consideration of your claim.

1. NAME: VINCENZO MAZZAMUTO POLICY#(s): H3236167

2. DATE OF BIRTH: 05 / 25 / 1955 (Month) (Day) (Year) SOCIAL SECURITY NUMBER: 196-56-5744

3. CURRENT ADDRESS: 501 LIMESTONE ROAD, CARLISLE, PA 17013
(*Provide complete street address*) City State Zip Code

4. TELEPHONE NUMBERS: Home (717)-243-0383 Business (717)-243-0383

5. OCCUPATION: PRESIDENT MONTHLY SALARY: $ 3,035.00
(*Provide occupation title and also fully complete the enclosed Insured's Statement of Occupational Duties and Employment form*)

6. NAME AND ADDRESS OF EMPLOYER (*Provide the full name of the business or practice if you are self-employed*):
VINNY, RESTAURANT, INC. 330 S. HANOVER STREET, CARLISLE, PA 17013

7. NATURE OF SICKNESS OR INJURY: HEART CONDITION
(*Specify the medical cause of your disability*)

8. INDICATE THE DATE YOU FIRST EXPERIENCED SYMPTOMS OF YOUR SICKNESS OR THE INJURY OCCURRED:
07 / 29 / 2000 (Month) (Day) (Year)

9. IF INJURY, DESCRIBE WHERE AND HOW THE INJURY OCCURRED (*If a Police or Accident Report was made, attach a copy of the report as well*): AT HOME - SUFFERED A HEART ATTACK

10. HAVE YOU EVER HAD THE SAME OR SIMILAR TYPE OF INJURY OR SICKNESS? YES ☐ NO ☒
(*If yes, give dates and details*):

11. DATE YOU FIRST CONSULTED WITH OR WERE TREATED BY A PHYSICIAN FOR THIS CONDITION: 07 / 29 / 2000 (Month) (Day) (Year)

12. PROVIDE THE NAMES AND ADDRESSES OF YOUR CURRENT DOCTOR, YOUR FAMILY PHYSICIAN, AND ALL OTHER PHYSICIANS OR MEDICAL PRACTITIONERS, HOSPITALS OR INSTITUTIONS, BY WHOM, OR IN WHICH, YOU WERE ATTENDED, TREATED OR EXAMINED DURING THE LAST 5 YEARS FOR THIS OR ANY OTHER MEDICAL CONDITION.

NAME	ADDRESS	DATES OF ATTENDANCE	REASON

13. WERE YOU UNABLE TO WORK OR DID YOU FILE A CLAIM FOR BENEFITS DUE TO A DISABILITY OF ANY TYPE WITHIN THE PAST 2 YEARS? YES ☐ NO ☐ (*If "YES", provide the source of benefits and the dates benefits were received*):

14. INDICATE THE DATES THAT YOU ARE CLAIMING POLICY BENEFITS DUE TO:

a.) TOTAL DISABILITY - FROM: 07 / 29 / 2000 (Month) (Day) (Year) TO: PRESENT / (Month) (Day) (Year)

b.) PARTIAL OR RESIDUAL DISABILITY - FROM: / / (Month) (Day) (Year) TO: / / (Month) (Day) (Year)

15. IF YOU HAVE NOT RETURNED TO WORK, WHEN DO YOU EXPECT TO RETURN TO WORK? N/A / / (Month) (Day) (Year)

16. IF YOU HAVE RETURNED TO WORK, DATE THAT YOU FIRST RETURNED TO ANY PART OF YOUR WORK: N/A / / (Month) (Day) (Year)

CONTINUED ON NEXT PAGE

17. THE FOLLOWING INFORMATION IS REQUIRED BY FEDERAL LAW:

a. Do you pay into SOCIAL SECURITY? YES ☒ NO ☐

b. If you are considered an employee or if you are self-employed and your business is incorporated, does your employer pay any portion of your insurance premium? YES ☐ NO ☒ NOT APPLICABLE ☐

c. If "YES", what percentage? _____% and is it reported as income to you? YES ☐ NO ☐

18. LIST ALL INSURANCE OR OTHER BENEFITS POTENTIALLY AVAILABLE TO YOU AS A RESULT OF YOUR CURRENT MEDICAL CONDITION BY ANSWERING WHETHER YOU HAVE APPLIED FOR ITEMS A-L BELOW AND PROVIDE THE ADDITIONAL RESPONSES REQUESTED FOR EACH BENEFIT APPLIED FOR.

Source of Benefits	Applied for? Yes	Applied for? No	Receiving? Yes	Receiving? No	Monthly Benefit	Company Name and Policy Numbers *(If applicable)*
a. Other New York Life Policies	☐	☒	☐	☒	$_____	_____
b. Medical Insurance	☐	☒	☐	☒	$_____	_____
c. Social Security	☐	☒	☐	☒	$_____	_____
d. Worker's Compensation	☐	☒	☐	☒	$_____	_____
e. State Disability	☐	☒	☐	☒	$_____	_____
f. Retirement / Pension	☐	☒	☐	☒	$_____	_____
g. Short Term Disability	☐	☒	☐	☒	$_____	_____
h. Salary Continuation	☐	☒	☐	☒	$_____	_____
i. Unemployment	☐	☒	☐	☒	$_____	_____
j. Union	☐	☒	☐	☒	$_____	_____
k. Auto/No-Fault Auto	☐	☒	☐	☒	$_____	_____
l. Other Policies: *(If none, indicate "None")*						
Name of Company						***Policy Number(s)***
_____	☐	☐	☐	☐	$_____	_____
_____	☐	☐	☐	☐	$_____	_____
_____	☐	☐	☐	☐	$_____	_____

IN FURNISHING THIS FORM, THE COMPANY DOES NOT ADMIT THE VALIDITY OF THIS CLAIM OR WAIVE ANY OF ITS RIGHTS OR DEFENSES. YOUR ELIGIBILITY FOR BENEFITS WILL BE DETERMINED IN ACCORDANCE WITH THE TERMS OF YOUR SPECIFIC POLICY CONTRACT(S) WITH US.

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

DECLARATION AND SIGNATURE

I declare that the answers provided on each page of this form and any attachments are complete and true to the best of my knowledge and belief. I understand that the Company reserves the right to require further information in order to evaluate my claim.

11-22-02
Date

Virgo Myatt
Signature of Insured (Insured or Insured's authorized representative)

_____
Relationship if other than Insured

FORM 2

NEW YORK LIFE INSURANCE COMPANY 51 Madison Avenue, New York, N.Y. 10010
NEW YORK LIFE INSURANCE AND ANNUITY CORP. (A Delaware Corporation)
NYLIFE INSURANCE COMPANY OF ARIZONA (Not Licensed in Every State)

368799

MEDICAL PROVIDER'S STATEMENT

(The patient is responsible for the completion of this form without expense to the Company)

Notice to Provider: Thank you in advance for your cooperation in completing this form on behalf of your patient identified below. We will consider this information in conjunction with other information gathered to determine the claimant's eligibility for benefits according to the terms of his or her specific contract(s) with us. We will periodically request that you provide updated information, records and chart notes to enable our evaluation of a continuing claim. In order for us to expedite our consideration of your patient's claim, please fully answer each question and sign and date the form where indicated.

1. PATIENT'S NAME: VINCENZO (First) MAZZAMUTO (Middle) (Last) DATE OF BIRTH: 5 (Month) / 25 (Day) / 55 (Year)

2. CURRENT MEDICAL CONDITION(s):
PRIMARY DIAGNOSIS: 414.01, V45.81, 410.70 ICD-9-CM CODE: _____
SECONDARY DIAGNOSIS: 729.1 ICD-9-CM CODE: _____

3. DATE THAT SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED: 7 (Month) / 22 (Day) / 00 (Year)

4. DATE THAT PATIENT FIRST CONSULTED YOU FOR THIS CONDITION: 7 (Month) / 22 (Day) / 00 (Year)

5. WAS PATIENT REFERRED TO YOU BY ANOTHER PRACTITIONER? YES ☐ NO ☒
(If "YES", please provide the name and address of that practitioner): _____

6. HAS THE PATIENT EVER HAD THE SAME OR SIMILAR INJURY OR SICKNESS? YES ☐ NO ☑
(If "YES", please provide details and dates of treatment): _____

7. HAVE YOU PREVIOUSLY TREATED THIS PATIENT? YES ☑ NO ☐ *(If "YES", provide diagnosis(es) and dates of prior treatment):* 729.1, 272.2 - multiple dates since 1992

8. OBJECTIVE FINDINGS *(Include x-ray, lab results and clinical findings. If pregnancy, also give LMP and EDC):* ⊕ MI by enzymes, ⊕ CAD by Cath

9. HAS PATIENT BEEN HOSPITALIZED? YES ☑ NO ☐ *(If "YES", provide reason, hospital name and dates of confinement):* Acute MI, Carlisle Hosp → Harrisburg Hospital for Cath 7/22/00 → 7/25/00

10. HAVE YOU COMPLETED CLAIM FORMS FOR OTHER INSURANCE CARRIERS? YES ☑ NO ☐
(If "YES", provide name of other insurance carrier(s)): UNUM

11. NATURE OF TREATMENT CURRENTLY BEING PROVIDED OR PLANNED *(Include surgery and medications prescribed if applicable):* Complete cardiac rehab, Follow up Stress test, Rx of anxiety and on going Rx of chronic low back pain

CONTINUED ON NEXT PAGE

MEDICAL PROVIDER'S STATEMENT
(CONTINUED FROM PREVIOUS PAGE)

12. HAVE YOU REFERRED THE PATIENT TO ANOTHER PHYSICIAN OR PRACTITIONER? YES ☒ NO ☐
(If "YES", please provide the name and address of all applicable physicians or practitioners):
Paul Ruani, MD, Mtht Pleas. Gen Assoc

13. IN YOUR OPINION, IS THE PATIENT ABLE TO WORK AT THIS TIME? YES ☒ NO ☒
IF "NO", WHEN DO YOU EXPECT THAT THE PATIENT WILL BE ABLE TO PERFORM SOME WORK? Unknown ____/____/____ (Month) (Day) (Year)

14. IS THERE ANY TYPE OF JOB MODIFICATION OR ACCOMMODATION THAT WOULD ENABLE THE PATIENT TO WORK AT THIS TIME? YES ☐ NO ☐ *(If "YES", please describe):* _____

15. BASED ON OBJECTIVE FINDINGS AND YOUR MEDICAL OPINION:
a.) THE PATIENT WAS UNABLE TO WORK FROM: 7 / 22 / 00 TO: Present
(Month) (Day) (Year) (Month) (Day) (Year)

b.) THE PATIENT WAS ABLE TO PERFORM SOME WORK FROM: ____/____/____ TO: ____/____/____
(Month) (Day (Year) (Month) (Day) (Year)

16. LIST ALL CURRENT RESTRICTIONS AND LIMITATIONS YOU HAVE PLACED ON THE PATIENT'S WORK AND PERSONAL ACTIVITIES DUE TO THEIR MEDICAL CONDITION *(If none, indicate "NONE"):*
Cannot be in Stressful Situations, no working 2 Shifts, No lifting

17. IS THE PATIENT COMPETENT TO ENDORSE CHECKS AND DIRECT THE USE OF THE PROCEEDS THEREOF? YES ☒ NO ☐

18. HAS THE PATIENT BEEN RELEASED FROM YOUR CARE? YES ☐ NO ☒

IF "YES", DATE THEY WERE RELEASED FROM YOUR CARE: ____/____/____ (Month) (Day) (Year)

IF "NO", DATE OF NEXT SCHEDULED TREATMENT OR EVALUATION: 01 / — / 01 (Month) (Day) (Year)

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

MEDICAL PROVIDER'S DECLARATION AND SIGNATURE

I declare that the answers on this statement are complete and true to the best of my knowledge and belief. I understand that periodic updates (including providing copies of medical records when requested) will be required in the event of a continuing claim.

Douglas J. Bower MD	23-1929361	717 249 1925
PHYSICIAN OR PROVIDER'S NAME (PLEASE PRINT)	*TAX ID/SOCIAL SECURITY #*	*TELEPHONE NUMBER*
220 Wilson St. Hbg Carlisle PA 17013	[signature]	11/15/00
STREET ADDRESS	*SIGNATURE OF PROVIDER*	*DATE SIGNED*

NEW YORK LIFE INSURANCE COMPANY 51 Madison Avenue, New York, N.Y. 10010
NEW YORK LIFE INSURANCE AND ANNUITY CORP. (A Delaware Corporation)
NYLIFE INSURANCE COMPANY OF ARIZONA (Not Licensed in Every State) 3687

INSURED'S STATEMENT OF OCCUPATIONAL DUTIES AND EMPLOYMENT

If you need additional space to answer any of the questions, please attach a sheet of paper with your additional answers.

1. NAME: VINCENZO MAZZAMUTO POLICY#(s): H3236167
2. OCCUPATIONAL TITLE(s): PRESIDENT
3. NAME AND ADDRESS OF EMPLOYER: VINNY'S RESTAURANT S. HANOVER STREET, CARI
   (Provide full name of Business and a complete street address)
4. NUMBER OF YEARS: IN OCCUPATION? 19 YRS.; EMPLOYED BY CURRENT EMPLOYER? 19 YRS.
5. HOW MANY HOURS DO YOU WORK DURING A NORMAL WORK WEEK? 40
6. LIST THE DUTIES OF YOUR OCCUPATION(s) IN ORDER OF THEIR IMPORTANCE. PROVIDE A DETAILE DESCRIPTION OF EACH. SHOW THE NUMBER OF HOURS AND PERCENT OF TIME YOU SPENT ON EACH IN NORMAL WORK WEEK IMMEDIATELY PRIOR TO THE ONSET OF YOUR CURRENT MEDICAL CONDITION:

- Duty: SUPERVISE EMPLOYEES Hours: 20 and % of time: 50 spent each week
  Description:
- Duty: BOOK KEEPING Hours: 10 and % of time: 25 spent each week
  Description:
- Duty: OTHER OFFICE DUTIES Hours: 10 and % of time: 25 spent each week
  Description:
- Duty: Hours: ____ and % of time: ____ spent each week
  Description:

Additional comments on Physical Requirements, Equipment/Tools Used:

INDICATE THE DATE YOU LAST WORKED IN THIS OCCUPATION: 07 / 28 / 2000
(Month) (Day) (Year)

7. INDICATE YOUR HIGHEST LEVEL OF EDUCATION COMPLETED:
   COLLEGE ☐ HIGH SCHOOL ☐ PRIMARY SCHOOL ☒ NUMBER OF YEARS COMPLETED? ____
8. PLEASE SPECIFY DEGREE(s), DIPLOMA(s), OR CERTIFICATE(s) OBTAINED AND AREA OF CONCENTRATION:
   n/a
9. PREVIOUS EMPLOYMENT *(If None, state "NONE")*:

OCCUPATION TITLE	NAME AND ADDRESS OF EMPLOYER	DATES EMPLOYED
n/a		

10. HOW HAS YOUR MEDICAL CONDITION INTERFERED WITH THE PERFORMANCE OF YOUR OCCUPATION?
    CANNOT PERFORM MY DUTIES UNDER THE STRESSFULL SITUATION. My chest is PAINFUL AND I AM FEARFUL FOR MY LIFE.

CONTINUED ON NEXT PAGE

11. ARE YOU PREDOMINANTLY RIGHT OR LEFT HANDED? RIGHT HANDED [X] LEFT HANDED [ ]

12. IN TERMS OF AN 8 HOUR WORKDAY, YOUR OCCUPATION(s) REQUIRED THAT YOU:

		Not at all	Occasionally (1/4 - 1 1/2 hrs)	Frequently (>1 1/2 - 5 1/2 hrs)	Continuously (>5 1/2 - 8 hrs)
	Bend/Stoop	[ ]	[X]	[ ]	[ ]
	Reach above Shoulder Level	[ ]	[X]	[ ]	[ ]
	Climb	[ ]	[X]	[ ]	[ ]
	Kneel	[ ]	[X]	[ ]	[ ]
	Balance	[ ]	[X]	[ ]	[ ]
Lift:	Usual number of pounds: 5 lbs	[ ]	[X]	[ ]	[ ]
	Maximum number of pounds: ____ lbs	[ ]	[ ]	[ ]	[ ]
Carry:	Usual number of pounds: 5 lbs	[ ]	[X]	[ ]	[ ]
	Maximum number of pounds: ____ lbs	[ ]	[ ]	[ ]	[ ]
Other:	_____		[ ]	[ ]	[ ]
	_____		[ ]	[ ]	[ ]

Sit	____ hour(s) at a time	3.5 total hour(s) in a day
Stand	____ hour(s) at a time	3.5 total hour(s) in a day
Walk	____ hour(s) at a time	1 total hour(s) in a day
Drive	____ hour(s) at a time	____ total hour(s) in a day

3. IF YOU ARE SELF EMPLOYED OR OWN ANY PERCENT OF THE BUSINESS NAMED IN QUESTION 3, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

a.) WHAT PERCENTAGE OF THE BUSINESS DO YOU OWN? 100 %

b.) INDICATE THE FORM OF THE BUSINESS: (check one)
CORPORATION [ ] PARTNERSHIP [ ] "S" CORPORATION [X] SOLE PROPRIETORSHIP [ ]

c.) NUMBER OF EMPLOYEES
PRIOR TO THE ONSET OF YOUR CLAIMED DISABILITY: FULL-TIME 7 PART-TIME 6
CURRENTLY: FULL-TIME 6 PART-TIME 4

d.) WITHIN THE LAST 6 MONTHS, HAVE YOU HIRED ANY EMPLOYEES TO PERFORM ANY OF YOUR JOB DUTIES? YES [ ] NO [ ]

e.) IS THE BUSINESS OPERATING AT THIS TIME? YES [X] NO [ ]

f.) HAS THERE BEEN ANY CHANGE OF OWNERSHIP OF THE BUSINESS IN THE LAST 6 MONTHS? YES [ ] NO [X]

g.) DO YOU HAVE PLANS FOR, OR ARE YOU CONTEMPLATING THE SALE OF YOUR SHARE OF THIS BUSINESS? YES [X] NO [ ]

NY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN PPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR HE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE CT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

DECLARATION AND SIGNATURE

declare that the answers provided on each page of this form and any attachments are complete and true to the best of my knowledge id belief. I understand that the Company reserves the right to require further information in order to evaluate my claim.

11-22-00
ate

Vinz Mynatt
Signature of Insured (Insured or Insured's authorized representative)

Relationship if other than Insured

B. Attending Physician's Statement (PLEASE PRINT)

UNUM

Name of Patient: MAZZAMUTO-VINCENZO
Date of Birth: 5/25/1955
Social Security Number:

Mail To: The Paul Revere Life Insurance Compa
New York Life Customer Care Cer
P.O. Box 15
Worcester, MA 01615-0

Claim Questions: 800.633.7506
Fax To: 508.751.7041

History

When did symptoms first appear or accident happen? 07/22/2000
Date restrictions and limitations began. 07/22/2000

Has patient ever had same or similar condition? If yes, state when and describe.
○ Yes ● No
__/__/____

Names and addresses of other treating physicians

Doctor's Name: Paul Pacini MD
Address (street, city, state, zip): Moffit, Reese & Lum Assoc

Doctor's Name:
Address (street, city, state, zip):

Diagnosis

Date of last examination: 10/04/2000

Diagnosis (including any complications) Include ICD9 and/or DSM IV Multi Evaluati
Nomenclature and Code Numbers: 414.01, V45.82, 410.70
272.2, 305.1, 300.02,

Subjective symptoms: Anxiety, Worry, Low back pain
Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings): Cardiac Cath 7/24

Is condition due to, or exacerbated by injury or sickness arising out of patient's employment? ● Yes ○ No ○ Unknown

Information about the patient's ability to work - this information is critical to understanding your patient's condition
Fully describe restrictions and limitations.

RESTRICTIONS (What the patient should not do): No pushing & Standing, No heavy lifting (2nd to back)
LIMITATIONS (What the patient cannot do): Cannot work in a stressful situations
What is the prognosis for recovery? Fair

Height / Weight: / 200 lbs
Blood pressure last visit: 112/80

If pregnancy, delivery type ○ Normal ○ C-Section
If pregnancy, expected delivery date: __/__/____
If delivered, actual delivery date: __/__/____

Treatment

Date of first visit for this illness or injury: 07/22/2000
Date of last visit: 10/04/2000
Date of next visit: 01/__/01
Frequency of visits: q 2-3 months

Progress

Has patient achieved maximum medical improvement? ○ Yes ○ No If no, complete the following:
How soon do you expect fundamental changes in the patient's medical condition? ○ 1 - 2 months ○ 5 - 6 months ● 3 - 4 months ○ more than 6 months
Is patient: ● Ambulatory ○ Bed Confined ○ House Confined ○ Hospital Confined

Has patient been admitted to hospital? ● Yes ○ No
Confined: From: 07/22/2000 To: 07/25/2000
If yes, give name and address of hospital: Carlisle Hospital, Harrisburg Hospital

*** REQUIRED ATTACHMENTS AND SIGNATURE**
Please make sure that office notes, test results, and discharge summaries are attached! This will help reduce additional requests.

FRAUD NOTICE
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Empl and Attending Physician portions of the claim form.
The above statements are true and complete to the best of my knowledge and belief.

Name (attending physician) Degree & Specialty: Douglas J. Bowman MD
Street Address: 220 Wilson St #100
City or Town: Carlisle
State or Province: PA
17013

Telephone Number: 717 249 1929
Fax Number: 717 249 6332
Tax I.D. Number: 23-1929361
Signature of Attending Physician (no stamp): X
Date: 11/15/00

Disability Claim
FOR EMPLOYER TO COMPLETE (PLEASE PRINT)

UNUM

C. Employer Section

Employer Name: VINNY'S RESTAURANT INC.

Employer Address: 330 SOUTH HANOVER STREET
CARLISLE, PA 17013

Policy Number: H3 236 167

Division Number / Class Number:

Division / Class Description:

Mail To: The Paul Revere Life Insurance Company
New York Life Customer Care Center
P.O. Box 15001
Worcester, MA 01615-0001

Claim Questions: 800.633.7506
Fax To: 508.751.7041

Employee's Name: VINCENZO MAZZAMUTO

Employee's Address: 501 LIMESTONE ROAD, CARL

Date of Birth: 05/25/1955

Social Security Number: 196-56-5774

Date of Hire: 01/01/1993

Effective Date of Insurance:

Termination Date:

Employee's Work Status:
(X) Full Time ( ) Exempt
( ) Part Time ( ) Non-exempt

How was employee paid? (please check one)
( ) Hourly ( ) Salary and Bonus
( ) Commissions ( ) Commissions Only
( ) Salaried ( ) Salary and Commissions

Occupation at last time worked: PRESIDENT

For STD Claims Only

Salary prior to date last worked: ***(refer to earnings definition in your contract)***
Please attach appropriate documentation

	Weekly	Bi-Weekly	Semi-Monthly
W-2 Earnings	$ 700.00	$	$
Overtime	$ prior year		
Commissions	$ per week		
Bonuses	$ per week		

Does the employee contribute toward the **STD** premium?
( ) Yes (X) No If Yes: ( ) Pre Tax ( ) Post Tax
If Post Tax: % paid by employer
% paid by employee

Does the employee contribute toward the **LTD** premium?
( ) Yes (X) No If Yes: ( ) Pre Tax ( ) Post Tax
If Post Tax: % paid by employer
% paid by employee

Year to Date Earnings (For FICA % Deductions): $ 20,300.00

For LTD Claims Only
Reporting the employee's annual, monthly, or weekly earnings

What is the earnings figure you use to compute premium payments for this employee? $ 36,400.00

Check the Definition of Earnings below that matches your contract for this employee and **attach the appropriate document(s).**

Definitions of Earnings: Please refer to your contract. (This Definition can be found in your contract.)

( ) **Salary Only / Current Earnings or Teacher's contract:**
Attach copy of payroll record or last two paystubs just prior to disability. If Teacher, attach copy of contract.

( ) If you contract covers **bonus** and/or **commissions**, submit payroll records for the 12 months or the 24 months (refer to the contract for the correct number of months) immediately preceding the last day worked, or the period of employment if less.

( ) **Previous Year's W-2 Form:**
Attach copy of the employee's W-2 form for the calendar year immediately preceding this disability.

( ) **Sole Proprietor:**
Attach From 1040 Schedule C for the three calendar years immediately preceding the disability.

( ) **Previous Year's K-1 Form (Partners):**
Attach a copy of the K-1 form of the year immediately preceding the disability. If your contract averages K-1 income over 3 years, attach prior 3 years K-1 forms.

( ) **All other definitions:**
For definitions other than those above that are based on salary as expressed on a particular document, send us a copy of the document.

Date of last salary increase: 01/01/2000

Employee's regular work schedule at time last worked: Days per week ____ Hours per day ____

Date paid through: For
( ) Salary continuation
( ) Vacation pay
( ) Accrued sick pay
( ) Other
__/__/____

Date last worked / number of hours worked that day: 07/28/2000 Hours per week 40

Has employee returned to work? If yes, date.
( ) Full Time
( ) Part Time
__/__/____ Hours per week ____

If this is a Flexible Benefits Plan, indicate which option of coverage this employee has chosen.

Previous Plan Year: Current Plan Year:

C. Employer Section (continued)

Prior LTD Carrier Name

Address

Effective Date __ __/__ __/__ __ __ __

Termination Date __ __/__ __/__ __ __ __

Is employee eligible for:	Yes	No	If yes, weekly or monthly amount	Weekly	Monthly	When do benefits begin?	When do benefits end?
Salary Continuation	O	O	$	O	O	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __
Other Disability Benefits	O	O	$	O	O	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __
State Disability	O	O	$	O	O	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __
Social Security	O	O	$	O	O	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __
Workers' Compensation	O	O	$	O	O	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __
Has Workers' Compensation claim been filed?	O	O	If yes, Name and Address of Carrier				
Health Insurance	O	O	If yes, Name and Address of Carrier				

If Workers' Compensation claim has been denied, please submit a copy of denial with this claim.

Information about your pension plan (Please send copy of Plan Summary) (do not complete for maternity claim)

Do you have a pension plan? O Yes ⊗ No

If yes, what type?
O Defined benefit O 401(k) O Other: (specify)
O Defined contribution O Profit sharing

Is employee eligible for your pension plan? O Yes ⊗ No

If eligible, does the employee participate? O Yes O No

What % does the employee contribute? _____ %

If the employee is participating, when is he or she eligible for benefits under the plan? __ __/__ __/__ __ __ __

General information about the employee's job

Job Title: PRESIDENT

Minimum education or training required: N/A

Does the employee perform supervisory functions? ⊗ Yes O No

If yes, how many people are supervised? 12

escribe job duties (or tach copy of job escription)

Duty	% of Time Spent at Duty
EXECUTIVE DUTIES	50%
OFFICE DUTIES	50%

lame of irect Supervisor: VINCENZO MAZZAMUTO

Telephone Number of Direct Supervisor: 717-243 0383

ttachments and Signature - Please attach a copy of the employee's job description if employee expected to be out of work for more than six weeks.

RAUD NOTICE
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

The above statements are true and complete to the best of my knowledge and belief.

Name of Person Completing Form: VINCENZO MAZZAMUTO

Telephone Number: 717-243-0383

Title of Person Completing Form: PRESIDENT

Fax Number:

Signature: V. Mazzamuto

Date Signed: 11-22-00

Telephone Number:

Not part of the Application

AGENT'S STATEMENT

ANSWER QUESTION 1 FOR ALL CASES

	Yes	No
1. A. If cash was collected with this application, did you give the receipt and explain that no coverage is provided under the receipt unless all conditions to coverage stated in it are met, and did you explain that such coverage is temporary and limited in the amount? If "No", cash must be refunded. (If Applicant did not give you the cash, give the name and address of the person who did in Question 7 below.)	☑	☐
B. Did you ask each question in the parts of the application for which you are responsible exactly as set forth, were the answers recorded exactly as made to you, and were all required signatures obtained in your presence? If "No", explain in Question 7 below	☑	☐
C. (i) Did the Proposed Insured communicate in English well enough to understand and answer each question in English including those on Non-Medical Part II, if applicable)?	☑	☐
(ii) If "No" to (i), who acted as interpreter? Agent ☐; Other ☐ If "Other", give name and relationship to Proposed Insured		
D. Are you aware of any information (including any prior rating or declination, physical condition, medical history, hazardous activities, alcoholic or drug habits, personal or financial reputation) which might affect the underwriting of the policy? If "Yes", explain fully in Question 7 below, even though this information may be disclosed in another part of the application	☐	☑
E. By reason of this transaction, is replacement involved? If "Yes", give details in Question 7 below	☐	☑

F. Annualized premium amount? $ 1427.00

G. Estimated First Year Commission? $ 785.00

H. How well do you know the Proposed Insured?

☐ Well, for..... years ☑ Met on solicitation ☐ Approached by Applicant

☐ Casually, for..... years ☐ Relative (Relationship.....)

2. Source? (A) ☑ My Client (B) ☐ Direct Mail (C) ☐ Group Contract
(D) ☐ Client Referral (E) ☐ Canvass (F) ☐ Customer List
(G) ☐ Unassigned Policyowner (H) ☐ Ad Response (I) ☐ Other

3. A. Proposed Insured's Occupation Class: 3A ; Occ. Code 941 Client ID (if known).....
B. Status: ☑ Self-employed, ☐ Salaried, ☐ Commissioned, ☐ Other.....

4. If policy is to be added to an existing C-O-M, Nyl-A-Plan, List Bill Arrangement, give:
A. Arrangement number (☐ C-O-M or ☐ Nyl-A or ☐ List Bill) .....
B. Type of Nyl-A-Plan Agreement: ☐ 8071, ☐ 8072 C. Name of Nyl-A-Plan .....

5. Medical Specialty Letter Requested? No ☑ Yes ☐ If "Yes", give Specialty.....

6. (A) POP DI? No ☑ Yes ☐ (Give Life policy # if known.)..... (B) Pro. Insd. County of Residence.....

7. Remarks, Additional Details .....

I DECLARE THAT: (a) the application was secured by me personally, and that I have no understanding or agreement with any other person, directly or indirectly, as to commissions or compensation on any policy applied for, except as may be specified below; and

(b) I have not paid or allowed, and I agree that I will not hereafter pay or allow, either directly or indirectly, any compensation or commission other than below, or any rebate of premium in any manner whatsoever to the Applicant or to any other person.

NYLCL00311

Name(s) of person(s) sharing commission NONE
(If commission is not to be shared, enter "none".)

Share of commission 100%

I HEREWITH SUBMIT the cash collected with this application. Date 8/28, 1993

Signature of Agent [signature]

Signature of any other person(s) sharing commission .....

OFFICE "Date Received" Stamp Here
AUG 30 11 47 AM '93

13

H-3-236167

SUPPLEMENT TO APPLICATION PART 1 TO NEW YORK LIFE INSURANCE COMPANY

Proposed Insured Vincenzo Mazzamuto Soc. Sec. No. 196-56-5744

SECTION 1 - BUSINESS OWNER'S STATEMENT - must be completed if Proposed Insured owns any portion of the business.

COMPLETE QUESTIONS 1 THROUGH 5 FOR ALL PLANS OF INSURANCE

1. Name of Business Vinny's Restaurant, Inc
2. Structure of Business: Sole Proprietor ☐ Partnership ☐ S Corp. ☐ Corp. ☑
3. Date the business was formed (if Corp. or S Corp., give date of incorporation) 1980
4. Percent of Business owned by Proposed Insured 100 %
5. Is the Proposed Insured's spouse employed by the same employer? Yes ☐ No ☑

COMPLETE QUESTIONS 6 THROUGH 10 WHEN APPLYING FOR OVERHEAD EXPENSE

6. How many partners or co-owners are there (including the Proposed Insured)? _____
7. Is the Proposed Insured actively employed full-time in the business ? Yes ☐ No ☐ If "No", explain _____
8. Number of full-time employees (including Proposed Insured) _____
9. Would the absence of the Proposed Insured result in a substantial loss of income to the firm? Yes ☐ No ☐
10. Can the Proposed Insured's duties be performed by an individual presently employed by the firm? Yes ☐ No ☐

COMPLETE QUESTIONS 11 THROUGH 15 ONLY WHEN APPLYING FOR DISABILITY BUY-OUT

11. How many partners or co-owners are there (including the Proposed Insured)? _____
12. Is the Proposed Insured actively employed full-time in the business ? Yes ☐ No ☐ If "No", explain _____
13. Number of full-time employees (including Proposed Insured) _____
14. Is there Disability Buy-Out coverage applied for (or already in force) on each partner or co-owner? Yes ☐ No ☐
    If "No", explain reason _____
15. Is it understood that as a requirement for the payment of benefits, a Buy-Out Agreement must be in effect and a Buy-Out effected? Yes ☐ No ☐

NOTE: THE PROPOSED INSURED CANNOT BE THE OWNER OF A DISABILITY BUY-OUT POLICY. THE OWNER MUST BE NAMED IN QUESTION 6 OF PART I OF THE APPLICATION

SECTION 2 - FINANCIAL INFORMATION

EARNED INCOME — Complete the chart below if the Proposed Insured owns any portion of the business. Fill in amounts as reportable for Federal income tax purposes.

	Current Annual Rate	Actual Last Year 19 92	Actual 2 Years Ago 19 91
(i) Proposed Insured's share of Gross Business Receipts	$184,494	$184,494	$364,521
(ii) Proposed Insured's share of Business Expenses (Include all salaries and contributions to deductible Pension or Profit Sharing Plans; do not include IRA or Keogh Plan contributions)	$131,455	$131,455	$323,783
(iii) For a Corporation, Proposed Insured's salary, wages, commissions, bonuses from the business, that are included in (ii) above	$_____	$_____	$_____
(iv) Contributions to any Pension or Profit Sharing Plan on Proposed Insured's behalf included in (ii) above	$_____	$_____	$_____
(v) Earned income from other sources, after deducting business expenses	$_____	$_____	$_____
(vi) Total Income (i) – (ii) + (iii) + (iv) + (v)	$53,039	$53,039	$40,738

Is 30% or more of (i) above ever generated in a single month? Yes ☐ No ☑

NYLCL00310

91-600 SUPP.

916001

No. V44

H. I. Policy No.
H3236167

HEALTH INSURANCE MEMORANDUM

This Memo. must be attached OVER all the papers of the Application to which it refers, and must not be detached therefrom.

DATE	NAME OF INSURED (PRINT) Vincenzo Mazzamuto	DRUM DATES
2/18/94	Typed PI prepared Ltr	

H-3 Cont. 5-68 Printed in U.S.A.

NYLCL00306

No. 144

H. I. Policy No. H322367

HEALTH INSURANCE MEMORANDUM

This Memo. must be attached OVER all the papers of the Application to which it refers, and must not be detached therefrom.

DRUM DATES

DATE	NAME OF INSURED (PRINT) Vincenzo Mazzamoto	
1/24	W544904932 (HPL) [illegible] from 6/93	
	[illegible] Please be advised that the C100 rider is not available s/c occ class 2A.	
	[illegible]	[illegible]
1/26	W544904932	
	[illegible]	
1/26	PHU [illegible]	[illegible]
1/27	PHU [illegible] on file	
	PCC - Ok to add 1000 AMI, change to 90 E.P. and mode to Semi-Annual	
	[illegible]	
1/31/94	H14 86-209 $21X pend.	[illegible]
2/16	[illegible]	
2/16	PCC Please change to non-smoker rated effective from start.	
	[illegible]	PCC

H185174

NYLCL00305

H-3-Cont. 5-48 Printed in U.S.A.

INDIVIDUAL HEALTH CHANGE TRANSMITTAL FORM
INDEX CHECK REQUIRED

☐ New Application Pending - Copy of Form 15015 Attached

To: Index Division Rm. 966 Check Insured or Other Member

Then To: Individual Health Change Unit Rm. 1053

Indicate in ☐ Office Originating Request

Date 1-12-94

☒ Gen. Off. and Code: Constitution V44 ☐ C.S.O.

Agent and Code: S. Ferrigno 022054

Insured: Vincenzo Mazzamuto

Policy # H3 1 236 167

Amt. of Remittance Rec'd. $

Date Cond. Temp. Cover Term

Insured's Date of Birth 5-25-55

Applicant's Date of Birth

☑ Requirements

	Policy		I.R. Requested
x	[illegible] 91-607		2274
x	Non-Med.		
	Med. Exam.		
x	Para Med HORL refer to 44904932		
	A.P.S. Requested		

Type of Change ☑

	Add Member D.O.B.
	Add Add'l. Ben. Rider
	Reinstatement
	Options
	Reconsider Rating non-smoker
	Other incr mon bene to $3000.00 waiting per 90 da 3 units ipo, 5% colb to age 65 w/residual & ~~unrestricted own occ rider to semiannual~~

DATE	FOR H.O. USE ONLY	DRUM DATES

H-116 2-84

NYLCL00297

CONSULTATION FORM

TO Tim

FROM _____ RETURN TO UNIT _____

TYPE CONSULT: ____ MEDICAL ____ OTHER

M.I.B. CODES: _____ _____

_____ _____

_____ _____

DESCRIPTION: Please note APP. - MED HX OK
However - Please note Date stopped smoking indicates 10/92 - New note stated indicates 2/92.

RECOMMENDATION: Suggest we take Dr's word & issue as smoker!

DATE: 6/25. SIG: A. McCray

RESPONSE:

appd Arnold

DATE: _____ SIG: _____

NYLCL00295

JUN 24 '93 12:04PM NY LIFE CONST GEN OFFICE P.2

NEW YORK LIFE INSURANCE COMPANY
DISABILITY INCOME UNDERWRITING

ATTENDING PHYSICIAN'S STATEMENT
UNDERWRITING INFORMATION

NAME OF PATIENT 3) INITIAL 4) LAST NAME	ADDRESS	GENERAL OFFICE CODE AND NAME
Vincenzo Mazzamuto DATE OF BIRTH 05/25/55	501 Limestone Road Carlisle, PA 17013	Constitution V44 AGENT Salvatore Perrigno

NAME OF APPLICANT AND RELATIONSHIP TO PATIENT	N.O. IDENTIFICATION	NAME OF DOCTOR	DATE
	H3 236 167	Dr. Terry Robinson	06/11/93

$40.00 [illegible] OF AGE OR YOUNGER, PLEASE COMPLETE REVERSE SIDE OF THIS FORM.

(1) Dates Attended MONTH	YEAR	Complaints & Abnormal Physical Findings	Duration of Illness	Diagnosis	Describe Treatment or Operation
2/93		(R) knee pain		→ Torn (R) meniscus	
Phone ms. [illegible] of:		Torn [illegible] [illegible] [illegible]			Poor Quality Original

(2) Laboratory Findings (including x-ray, ECG, BMR and pathological reports, etc., with dates)

2/93 MRI - Torn (R) medial meniscus

(3) Present condition, if known? (include sequelae and complications of above reported illnesses)

(4) Have any other physicians or surgeons been consulted? If so, please give name, date and nature of disorder.

Dr. [illegible] - [illegible] 2/93.

(5) Please record any other medical information which has a bearing on this person's health including cigarette smoking.

(+) Smoker 2-3 PPD Quit 10/92
[illegible]

DATE 6/21 19 93 SIGNATURE [signature] M.D.

STREET ADDRESS 220 [illegible] St. CITY OR TOWN [illegible] STATE PA. ZIP CODE 17013

H-17374B 9-87

This form was developed by the Health Insurance Council and approved by the Council on Medical Services of the A.M.A. in 1965.

HEALTH INSURANCE COUNCIL

NYLCL00292

Jan 21 9 17 AM '93

INFOLINK SERVICES
Hooper Holmes, Inc.
Order# : 371 32616
Company: 00629-001

C O N F I D E N T I A L

District / Agency: CONST V44
Policy Number: H3 236 167

For customer service, call: (509)428-8886
Date Requested:
Date Received: 06/05/93

Name: VINCENZO *. MAZZAMUTO
Address: 501 LIMESTONE RD
CARLISLE PA 17013

Date of Birth: 05/25/55
Soc. Sec. #:
Monthly Disability: 0

Beneficiary Name/Relationship:

SOURCES: [X] Applicant [ ] Employer
[ ] Spouse [ ] Other adult family member

Other adult family member name/relationship - Confirming sources/known

IDENTIFICATION:	No/Yes	PROVIDE DETAILS OF Yes ANSWERS
1. Name Incorrect?	[N]o	
2. Date of Birth Incorrect?	[N]o	
3. Residence address Incorrect?	[N]o	
a. Less than 1 yr. at Res.?	[N]o	
(If Yes, give prev. addr(e):		
4. Beneficiary Incorrect?	[N]o	

Poor Quality Original

5. Applicant's marital status: [M] [M]d. [S]ing. [W]id. [D]iv. s[e]p.

EMPLOYMENT: 1.Employer's Name: GENOVA'S
2.Job Title: OWNER 3. Employed for: 7 YEARS
3a. Former employer, if less than 1 yr. at job:
4. Line of Business: PIZZA & ITALIAN RESTAURANT 5. # of Employees: 6
6. Duties: MANAGES THE RESTAURANT, DOES PURCHASING AND BOOKKEEPING 60% OF THE TIME AND MAKES PIZZAS 40% OF THE TIME. HE OWNS 100% OF THE BUSINESS.

INCOME/FINANCIAL: 1. Annual Earned Income: $ 110,000
2. Annual Unearned Income: $ 30,000

2a. Source: rent,dividends,etc..?
RENTAL INCOME

3. Estimated Net Worth: $ 1,000,000 4. Spouse's Income: $ 10,000

	No/Yes	PROVIDE DETAILS OF Yes ANSWERS
5. Annual earned income figure above exact? (If not, explain)	[Y]es	
6. Any bonus or profit sharing?	[N]o	
7. Covered by State Disability Benefit Program?	[N]o	
8. Any other Disability Income in force or applied for?	[N]o	
9. Any periods of absenteeism from job or other potential drains on income?	[N]o	
10. Any financial problems, such as bankruptcy,judgements,liens?	[N]o	

NYLCL00288

JUN 16 9 37 AM '39

1. Based on occupational duties of _____ any policy issued will be, _____ at best, occupational class _____. Advise if acceptable. Information from IR.

2. Based on annual earned/unearned income of _____ any policy issued will be at best for _____ and SIS rider _____. We will consider if furnished with factual proofs of earned (net) income.

3. Based on annual earned/unearned income of _____ and other coverage in force with _____, any policy issued will be at best _____ and SIS _____. Will reconsider if furnished with factual proofs of earned (net) income.

4. We have reason to believe that the proposed insured has a monthly income policy in force/pending with _____. Advise amount, BENEFIT PERIOD; status of policy.

5. Based on MIB information, we have reason to believe that the proposed insured may not have given us full details in answer to questions of Part II. Please secure a new non-medical Part II with special attention to such questions 3c.

6. Based on history of _____, any policy issued will require a _____ Rider. We can consider on a standard basis with a _____ day waiting period. Advise if acceptable.

7. Based on history of _____, any policy issued will require a _____ special class extra premium. We can consider on a standard basis with a _____day waiting period. Advise if acceptable.

8. Based on history of _____, any policy issued will include a rider and/or a special class _____ extra premium on _____. As this is a replacement, advise if acceptable.

9. Based on occupational class of _____ we cannot offer Plan _____. Can consider for _____. Advise if acceptable.

10. Based on _____ history, any policy issued will require a _____ Rider with a _____ day waiting period. All other conditions will have _____ day waiting period.

11. We still have not received SRC documents. Please advise when they will be forwarded.

12. Because Nylic group disability benefits, which proposed will be eligible for integrate with Social Security, it is to proposed insured's benefit to apply for total amount in base policy. If desired, we can consider as applied for. Please advise.

13. Advise proposed insured's residency status, years in U.S. and does proposed insured intend to remain in the U.S. permanently.

14. It is difficult for us to accept an application on an individual at this age who has never seen a physician. Please advise name of Attending Physician, dates and reasons consulted.

NYLCL00284

ACKNOWLEDGEMENT

I have been given a copy of "Information Practices Related to Underwriting Your Application" which tells how New York Life Insurance Company and New York Life Insurance and Annuity Corporation obtain and use data about me. It includes the notice required by the state and federal Fair Credit Reporting Acts and a description of MIB, Inc. (Medical Information Bureau).

AUTHORIZATION

(In this Authorization, "the Insurer" means New York Life Insurance Company or New York Life Insurance and Annuity Corporation, whichever applies.)

In order to see if (and on what basis) I qualify for insurance or for the benefits which that insurance may provide, I authorize the following:

MEDICAL INFORMATION Physicians or practitioners; hospitals; medical or medically related facilities; laboratories; insurance companies; or MIB may give to the Insurer (or any consumer reporting agency acting in its behalf) and to any of its reinsurers data and copies of records that they may have about my physical and mental health. The data and records may include important history, findings, diagnoses and treatment.

OTHER UNDERWRITING INFORMATION MIB and other insurance companies may give to the Insurer and to any of its reinsurers data about: my driving record; any criminal activity or association; hazardous sport or aviation activity; use of alcohol or drugs; any claim of eligibility for disability income benefits; and other applications for insurance.

EXAMINATIONS AND TESTS The Insurer may obtain physical examinations or medical tests deemed necessary to underwrite my application. These tests (where permitted by law) may include, but are not limited to, electrocardiograms, chest x-rays, and tests of blood and urine to determine, among other things, exposure to causative agents of disease (for example, exposure to the AIDS virus) and the presence of drugs. However, a separate notification/authorization form will be provided with respect to testing for the AIDS virus.

INVESTIGATIVE CONSUMER REPORT The Insurer may obtain an investigative consumer report and may give the consumer reporting agency information concerning the amount and type of my coverage and my use, if any, of tobacco. The report may add to or confirm the types of data mentioned above. It may also contain data about: my identity; age; residence; marital status; past and present jobs (including work duties); economic conditions; driving record; personal and business reputation in the community; and mode of living; but will not include any information relating directly or indirectly to sexual orientation.

IDENTIFICATION To obtain the data described above, the Insurer may give my name, address, and date, and place of birth to the above persons or organizations.

RELEASE OF INFORMATION TO OTHERS When necessary, the Insurer may give data about me that affects my insurability to: its subsidiaries; its affiliates; its parent company; its agents and their staffs; its reinsurers; and the Insurer and its reinsurers may give such data to MIB. However, this will not be done in connection with information relating to the AIDS virus.

I also authorize the release of these same types of data about any of my children who are to be insured.

This authorization shall be valid for 30 months from the date shown below. A photocopy of it shall be as valid as the original.

In giving this authorization, I release the above parties from all liability in the securing and use of the above underwriting data.

I know that a copy of this form is in the Insurer's statement on "Information Practices Related to Underwriting Your Application."

Date 6/3, 1993

Witness _____ Agent

Signature of Proposed Insured (Annuitant)

Signature of Spouse, if proposed for coverage; or
Signature of Parent or Guardian, if Proposed Insured (Annuitant) is Under 14 years 6 months

NYLCL00283

Not part of the Application

AGENT'S STATEMENT

ANSWER QUESTION 1 FOR ALL CASES

	Yes	No
1. A. If cash was collected with this application, did you give the receipt and explain that no coverage is provided under the receipt unless all conditions to coverage stated in it are met, and did you explain that such coverage is temporary and limited in the amount? If "No", cash must be refunded. (If Applicant did not give you the cash, give the name and address of the person who did in Question 7 below.)	☑	☐
B. Did you ask each question in the parts of the application for which you are responsible exactly as set forth, were the answers recorded exactly as made to you, and were all required signatures obtained in your presence? If "No", explain in Question 7 below	☑	☐
C. (i) Did the Proposed Insured communicate in English well enough to understand and answer each question in English including those on Non-Medical Part II, if applicable)?	☑	☐
(ii) If "No" to (i), who acted as interpreter? Agent ☐; Other ☐ If "Other", give name and relationship to Proposed Insured	☑	☐
D. Are you aware of any information (including any prior rating or declination, physical condition, medical history, hazardous activities, alcoholic or drug habits, personal or financial reputation) which might affect the underwriting of the policy? If "Yes", explain fully in Question 7 below, even though this information may be disclosed in another part of the application	☐	☑
E. By reason of this transaction, is replacement involved? If "Yes", give details in Question 7 below	☐	☑

F. Annualized premium amount? $ 1427.00

G. Estimated First Year Commission? $ 785.00

H. How well do you know the Proposed Insured?

☐ Well, for ____ years ☑ Met on solicitation ☐ Approached by Applicant

☐ Casually, for ____ years ☐ Relative (Relationship ____)

2. Source? (A) ☑ My Client (B) ☐ Direct Mail (C) ☐ Group Contract
(D) ☐ Client Referral (E) ☐ Canvass (F) ☐ Customer List
(G) ☐ Unassigned Policyowner (H) ☐ Ad Response (I) ☐ Other

3. A. Proposed Insured's Occupation Class: 3A ; Occ. Code 491 Client ID (if known) ____

B. Status: ☑ Self-employed, ☐ Salaried, ☐ Commissioned, ☐ Other ____

4. If policy is to be added to an existing C-O-M, Nyl-A-Plan, List Bill Arrangement, give:

A. Arrangement number (☐ C-O-M or ☐ Nyl-A or ☐ List Bill) ____

B. Type of Nyl-A-Plan Agreement: ☐ 8071, ☐ 8072 C. Name of Nyl-A-Plan ____

5. Medical Specialty Letter Requested? No ☑ Yes ☐ If "Yes", give Specialty ____

6. (A) POP DI? No ☑ Yes ☐ (Give Life policy # if known.) ____ (B) Pro. Insd. County of Residence Cumberland

7. Remarks, Additional Details ____

I DECLARE THAT: (a) the application was secured by me personally, and that I have no understanding or agreement with any other person, directly or indirectly, as to commissions or compensation on any policy applied for, except as may be specified below; and

(b) I have not paid or allowed, and I agree that I will not hereafter pay or allow, either directly or indirectly, any compensation or commission other than below, or any rebate of premium in any manner whatsoever to the Applicant or to any other person.

Name(s) of person(s) sharing commission None
(If commission is not to be shared, enter "none")

Share of commission 100%

I HEREWITH SUBMIT the cash collected with this application. Date 6/3, 1993

Signature of Agent [signature]

Signature of any other person(s) sharing commission ____

JUN 3 1 19 PM '93
CUSTITUTION
O, V44
OFFICE "Date Received" Stamp Here

NYLCL00282

PT 702765

APPLICATION PART I TO NEW YORK LIFE INSURANCE COMPANY (Continued)

THOSE WHO SIGN THIS PART I AGREE THAT:

1. All of the statements in the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those who made them.

2. No agent or medical examiner has any right to accept risks, make or change contracts, or give up any of the Company's rights or requirements.

3. "Cash Paid" with the application with respect to a new policy or additional benefit provides a limited amount of temporary coverage for up to 60 days, if the terms and conditions of the receipt are met. If an option to increase the amount of income protection is being exercised, it must be available in the policy indicated, and no coverage will be provided before the Option Date. Temporary coverage is not provided if reinstatement of a policy is applied for.

4. To put a policy or benefit issued in response to this application into effect, the policy or written evidence of the benefit must be delivered to the Applicant and the full first pr paid. If temporary coverage with respect to a policy or b is not in effect at time of delivery, there must not have any material change in the insurability of the Proposed In as described by the application's written statements means that these statements would still be complete an if made at time of delivery.

5. If this application is in connection with a reinstatement agreed that payment of the overdue premium to New Life Insurance Company will be applied to a period bet the date the policy lapsed and the date of reinstatem

6. Under penalties of perjury, it is certified that: (a) The S Security or tax numbers shown in this application are co taxpayer identification numbers; and (b) the holders of numbers are not subject to any backup withholding of Federal income tax.

Dated at Carlisle, PA

on 6/3 19 93

I certify I have truly and accurately recorded all answers given to me.

Witness [signature]
Agent

Countersigned by Licensed Resident Agent (if required)

[signature]
Signature of Appli

Signature of Proposed Insured if other than Appli

NYLCL00275

91-607

91607

04:23PM NY LIFE CONST GEN OFFICE

ED.

☐ NEW YORK LIFE INSURANCE COMPANY
☐ NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (A Delaware Corp.)
51 Madison Avenue, New York, N.Y. 10010

Policy Number (if known)?

Answers to the Paramedical Examiner, forming Part Application for Insurance. Complete this form in pr

Name of Person Examined? Vincenzo Mazzonato b. Date of Birth? Mo: 5 Day: 25 Yr: 55 c. Soc. Sec. or Soc. Ins. No.? 196 56 574

2. Personal Physician (If none, or if not consulted in last 5 yrs., so state.)
a. Name? Mosko Associates (Terry Robinson D.O.) Carlisle Pa. 17013
b. Address and Phone No.? Same as above
c. Last consulted: Date? 2 1/2 months Reason? knee injury
d. Treatment: Type? Evaluation Medication? N/A

Give the following information, so far as known, for the person being examined. If "Yes" to any question, give full details in Question 11.

3. In last 10 years, has such person consulted a physician or practitioner for, been treated for, had, or been informed that he or she had	Yes	No
a. heart trouble, angina, stroke, murmur or irregular pulse?	☐	☒ a
b. diabetes or elevated blood sugar?	☐	☒ b
c. chronic bronchitis, emphysema, asthma or other lung disorder?	☐	☒ c
d. cancer, tumor, lymphoma; lupus or collagen disorder; rheumatoid arthritis or muscular disease?	☐	☒ d
e. pancreatitis; urine sugar; hepatitis, cirrhosis or liver trouble?	☐	☒ e
f. AIDS, AIDS-related complex (ARC), or other immune deficiency?	☐	☒ f
g. elevated blood pressure; thrombophlebitis, embolism or other circulatory disorder; kidney disease; albumin or blood in urine?	☐	☒ g
h. ulcerative colitis, ileitis or other chronic intestinal disorder?	☐	☒ h
i. seizures, dizziness or fainting; other nervous system disorder?	☐	☒ i
j. anemia, thyroid or other blood or gland disorder?	☐	☒ j
k. ulcer; hernia; varicose veins; gall bladder disorder; kidney stones?	☐	☒ k
l. back, spine, joint or bone disorder; eye, ear or skin disorder?	☐	☒ l
m. (If a male) disorder of prostate or reproductive organs? (If a female) disorder of pelvic organs, breasts, menses or pregnancy, or is she now pregnant?	☐	☒ m
4. Is any such person now taking prescription medication?	☐	☒

5. In last 2 years, has any such person had any of the following:	Yes
a. unexplained weight loss or swollen glands; recurring diarrhea; fever or infection; persistent cough, pneumonia, or thrush?	☐
b. chest discomfort, edema, transient visual loss, muscle weakness, shortness of breath, or internal bleeding?	☐
6. In last 10 years, has any such person been counselled, treated or hospitalized for any psychiatric, emotional or mental health condition, or for the use of alcohol or drugs?	☐
7. Other than as stated, has any such person during past 2 years had a. treatment or surgery in a hospital or other facility?	☐
b. an electrocardiogram, x-ray or other diagnostic test, or an examination for checkup or other purpose?	☐
c. advice about any treatment, surgery or diagnostic testing which was not completed?	☐
8. Has any such person, for physical or mental health reasons, ever received disability benefits, compensation or pension; or been rejected for, or discharged from, military service?	☐
9. Any history of angina, heart trouble or stroke before age 60 among natural parents, brothers or sisters of any such person? If "Yes", give relationship, age at onset and subsequent history.	☒
10. Has such person smoked any cigarettes in the past 12 months?	☐

11. GIVE FULL DETAILS FOR EACH "YES" ANSWER IN QUESTIONS 3-10

a. Ques. No.	b. Reason — nature and severity of condition? (Include frequency, treatment, medication, surgery and results.)	c. Onset? Mo. Yr.	d. Recovery? Mo. Yr.	e. Names and Addresses of Physicians Hospitals or Medical Facilities?
(9)	Father: Stroke prior to age 60.			

NYLCL00272

THE UNDERSIGNED DECLARE THAT, to the best of their knowledge and belief, all answers given in this Part II are correctly recorded, complete and tr

Dated at Carlisle Pa. on 5-19 19 93

I certify I have truly and accurately recorded all answers given to me.

Witnessed by [signature] RPMT
Signature & title of person completing Questionnaire

x Vincenzo Mazzonato
N/A
Signature of person examin

Signature of Parent or Guardian, if person examined is under 14 years 6 mont

JUN 9 93 16:06 9885

1 215 664 7270 PAGE.002

NON-MED.

☒ NEW YORK LIFE INSURANCE COMPANY
☐ NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (A Delaware Corp.)
51 Madison Avenue, New York, N.Y. 10010

Policy Number (if known)?

Answers to Insurer forming Part II of Application for Insurance. (Please print or type.)

Full information on all persons proposed for coverage in Question 1. (Use Question 11 for all details requested in Questions 2-11.)

1. a. PROPOSED INSURED? Vincenzo Mazzamuto Height? 5 ft. 6 in.; Weight? 195 lbs.
b. SPOUSE, if proposed for coverage? Height? ft. in.; Weight? lbs.
c. CHILDREN, if proposed for coverage (give full names)?

2. Personal physicians (give consultation details in Ques. 11) Name? Address and Phone No.? Date last consulted?
a. For Proposed Insured Masland Medical Associates 220 Wilson St. Ste. 109 1 month ago
b. For Spouse named in Ques. 1 (717)249-1929 Carlisle, PA 17013

Answer Questions 3-11, so far as known, for all persons in Ques. 1. (If "Yes" to Ques. 6, submit CPHQ Form 17480 for that person, and give name in Ques. 11.)

3. In last 10 years, has such person consulted a physician or practitioner for, been treated for, had, or been informed that he or she had	Yes	No
a. heart trouble, angina, stroke, murmur or irregular pulse?	☐	☒ a
b. diabetes or elevated blood sugar?	☐	☒ b
c. chronic bronchitis, emphysema, asthma or other lung disorder?	☐	☑ c
d. cancer, tumor, lymphoma; lupus or collagen disorder; rheumatoid arthritis or muscular disease?	☐	☒ d
e. pancreatitis; urine sugar; hepatitis, cirrhosis or liver trouble?	☐	☑ e
f. AIDS, AIDS-related complex (ARC), or other immune deficiency?	☐	☒ f
g. elevated blood pressure; thrombophlebitis, embolism or other circulatory disorder; kidney disease; albumin or blood in urine?	☐	☒ g
h. ulcerative colitis, ileitis or other chronic intestinal disorder?	☐	☒ h
i. seizures, dizziness or fainting; other nervous system disorder?	☐	☒ i
j. anemia, thyroid or other blood or gland disorder?	☐	☒ j
k. ulcer; hernia; varicose veins; gall bladder disorder; kidney stones?	☐	☒ k
l. back, spine, joint or bone disorder; eye, ear or skin disorder?	☐	☒ l
m. (if a male) disorder of prostate or reproductive organs? (if a female) disorder of pelvic organs, breasts, menses or pregnancy, or is she now pregnant?	☐	☒ m
4. Is any such person now taking prescription medication?	☐	☒

5. In last 2 years, has any such person had any of the following:	Yes	No
a. unexplained weight loss or swollen glands; recurring diarrhea, fever or infection; persistent cough, pneumonia, or thrush?	☐	☒ a
b. chest discomfort, edema, transient visual loss, muscle weakness, shortness of breath, or internal bleeding?	☐	☒ b
6. In last 10 years, has any such person been counselled, treated or hospitalized for any psychiatric, emotional or mental health condition, or for the use of alcohol or drugs? (If yes, submit CPHQ.)	☐	☒
7. Other than as stated, has any such person during past 2 years had		
a. treatment or surgery in a hospital or other facility?	☐	☒ a
b. an electrocardiogram, x-ray or other diagnostic test, or an examination for checkup or other purpose?	☐	☒ b
c. advice about any treatment, surgery or diagnostic testing which was not completed?	☐	☒ c
8. Has any such person, for physical or mental health reasons, ever received disability benefits, compensation or pension; or been rejected for, or discharged from, military service?	☐	☒
9. Any history of angina, heart trouble or stroke before age 60 among natural parents, brothers or sisters of any such person? If "Yes", give relationship, age at onset and subsequent history.	☒	☐
10. Has Prop. Insured smoked any cigarettes in the past 12 months?	☐	☒

11. GIVE FULL DETAILS FOR EACH "YES" ANSWER IN QUESTIONS 3-5, 7-9, AND LAST CONSULTATION WITH PERSONAL PHYSICIAN IN PAST 2 YEARS

a. Ques. No.	b. Name of Person to whom "Yes" applies	c. Reason — nature and severity of condition? (Include frequency, treatment, medication, surgery and results.)	d. Onset? Mo. Yr.	e. Recovery? Mo. Yr.	f. Names and Addresses of Physicians, Hospitals or Medical Facilities?
9	Father	Stroke prior to age 60			
		PT. last consulted Dr. Robinson 4/93 Sore knee injury - fully recovered - no further treatment need.			

NYLCL00271

THE UNDERSIGNED DECLARE THAT, to the best of their knowledge and belief, all answers given in this Part II are correctly recorded, complete and true.

Dated at Carlisle, PA on 6/3, 1993

I certify I have truly and accurately recorded all answers given to me.

Witnessed by Agent

Signature of Proposed Insured

Signature of Spouse, if proposed for coverage; Signature of Parent or Guardian, if Prop. Insured under 14 years 6 months

988-510

988510

NOT PART OF THE APPLICATION

RULES AND INSTRUCTIONS FOR COMPLETION OF NON-MEDICAL APPLICATION PART II

If an Application Part II is required, it must be a Non-Medical Part II, unless a medical or paramedical examination is required because of age and amount or because the case is not suitable for non-medical (see Section 1 below). On all applications submitted on a non-medical basis (including simplified underwriting), the Agent must see the Proposed or Other Covered Insured and the spouse (if proposed for coverage) at the time they sign the application, and be satisfied that they appear to be normal, healthy and satisfactory risks for insurance coverage. (A separate Non-Medical Part II should be completed for the Other Covered Insured.)

1. **Caution: Proposed Insured, Spouse or Other Covered Insured Not Suitable for Non-Medical**

(a) Persons with a medical impairment for which a medical or paramedical examination is required regardless of age or amount. The Agents' Manual and the Health Insurance Rate Book list some significant impairments requiring a Medical or Paramedical Part II.

(b) Persons whose applications have been obtained by mail. The Agent should attach a letter explaining why it was necessary to do this.

(c) Citizens of foreign countries, unless they have resided continuously in the U.S. or Canada for at least one year (two years, if disability income).

(d) If the Agent is to be Applicant, Owner, Beneficiary or Assignee, any person who is not a member of the Agent's family or is not related by blood or marriage to the Agent. Prior approval for such cases must be obtained from the Home Office. A Paramedical or Full Medical Application Part II (whichever is applicable) will always be required.

2. **Signatures on Non-Medical and Authorization Forms**

(a) A spouse proposed for life or disability income coverage must also sign the Part II.

(b) If the Proposed Insured is a child under 14 years and 6 months old, a parent or guardian who is living with the child must answer the questions with respect to the child and must sign the Part II. The child, if age 9 or over and is able to write, should sign in the space provided.

(c) The Non-Medical Application Part II must be signed in the presence of the Agent.

(d) All persons (Proposed Insured, spouse, parent or guardian) who signed Application Part II must also sign the authorization form.

3. **New Business Transactions** (Note: The policy number will be entered by the Home Office.)

Question 1: The height should be height in shoes, if normal heel size; and the weight should be the weight in indoor clothing.

Question 2: Note that the name, address and phone number of the Proposed Insured's personal physician and the date last consulted are to be given in Question 2. **If the Proposed Insured does not have a personal physician, enter "none" in Question 2, as applicable.**

Question 3: Circle each item to which a "Yes" answer applies, and give full details in Question 11.

Question 9: This question pertains to the family history of the Proposed Insured only. If a natural parent, brother or sister developed angina, heart trouble or stroke before age 60, indicate condition and age at onset in Question 11. For subsequent history: if family member is deceased, give cause of death and age at death; if family member is living, give age and condition of health.

Question 11: Indicate, if possible, the month and year of onset of and recovery from any medical history. It is not necessary to repeat any physician's address given in Question 2. If more space is needed for details, use Question 11 of another Non-Medical Part II. All Part II forms must be signed by the same persons and attached together.

4. **After Issue Transactions:** Include Policy Number in the upper right corner of the Part II. The other instructions in Item 3 above also apply to Questions 1, 2, 3, 9 and 11, when answered in connection with reinstatement, addition of benefits or other after issue transactions.

5. **Rules for Obtaining Additional Requirements on Non-Medical Cases.** Listed below are the additional requirements which must be obtained for Life policies, when the indicated portion of Question 3 on the reverse side is answered "Yes".

If "Yes" to Question	Obtain Requirements	Obtain APS	If "Yes" to Question	Obtain APS
3a	M and E	5	3h	5
3b	P and E	5	3i	5
3c	P	5	3j	2
3d	P	5	3m	2
3e	P and B	5		
3f	—	—		
3g	P and E	2		

M Medical Exam
P Paramedical Exam
B Blood — Urine kit

E ECG for amounts of $100,000 and over at issue ages 40 and older
2 or 5 Obtain APS, if physician seen within past 2 or 5 years, as applicable

NYLCL00270

UNDERWRITING ACTION
(SHEET III)

POLICY NUMBER K 32367 67

1. CHANGE THE FOLLOWING DATA: REASON — AMEND / UIL / RECON TXS

Amend Q3-4 Pt II intended to be 'yes'

2. APP APPROVED 5 SMOKER Y REINS N RECALL ☐
APP DECLINED ____ NO TEMP COVRG ☐ REASON ____
FCRA: AGENCY, CITY, STATE ____ STATE OF: ____

3. PROPOSED INSURED: OCC CODE 130 CL 2A (603S7)
BASIC RTG 100 RP: SYS ____ DIA ____
CHANGED BECAUSE OF duty duties — 7H 0

MIB	DEBIT	TOTAL RTG	SPECIAL CLASS	IMP CODE	ROR	Reason

SPOUSE: BASIC RTG ____ RP: SYS ____ DIA ____

Poor Quality Original

MIB	DEBIT	TOTAL RTG	SPECIAL CLASS	IMP CODE	ROR	Reason

IF RATED OR DELETED CHILD'S FIRST NAME-RELATIONSHIP	TOTAL RTG	SPECIAL CLASS	IMP CODE	ROR	Reason

ISSUE AND DELIVERY INSTRUCTIONS

4. ATTACH TO EACH POL COPIES OF:
ORIG APP PART I
ORIG APP PART II
PARA MED
ADD'L PART II
SIGS
DISCLOSURE STATEMENT

REQUIREMENTS BEFORE DELIVERY
☐ (3) SEP PART I SIGNED BY
☐ SEP PART II
☐ (24) UK
☑ (3) AMENDMENT
☐ CHANGE PREVIOUS (851) SENT
☐ WSC

☑ (4) DEDX
☐ (8) YSHO
☑ (6) COM
☐ YCO
☐ SMOKER NOTICE
☐ LIST BILLING NOTICE
☐ DISCLOSURE STATEMENT

REMARKS ____

6/28 DATE

UNDERWRITER

NYLCL00269

-236-167

INDIVIDUAL HEALTH CHANGE TRANSMITTAL FORM
INDEX CHECK REQUIRED

☐ New Application Pending - ~~Copy of Form 15015 Attached~~

To: Index Division Rm. 966 Check Insured or Other Member

Then To: Individual Health Change Unit Rm. 1053

Indicate in ☐ Office Originating Request

Date 1-12-94

☒ Gen. Off. and Code: Constitution ☐ C.S.O.
V44

Agent and Code: S. Ferrigno 022054

Insured: Vincenzo Mazzamuto

Policy # H3 1 236 167

Amt. of Remittance Rec'd. $_____

Date Cond. Temp. Cover Term. _____

Insured's Date of Birth 5-25-55

Applicant's Date of Birth

☑ Requirements

	Policy		I.R. Requested
x	~~00-000~~ 91-607		2274
x	Non-Med.		
	Med. Exam.		
x	Para Med HORL refer to 44904932		
	A.P.S. Requested		

Type of Change ☑

	Add Member	D.O.B.
	Add Add'l. Ben. Rider	
	Reinstatement	
	Options	
	Reconsider Rating non-smoker	
	Other incr mon bene to $3000.00 waiting per 90 da 3 units ipo, 5% colb to age 65 w/residual & ~~unrestricted own occ mode to semiannual~~	

DATE	FOR H.O. USE ONLY	DRUM DATES

NYLCL00266

H-118 2-84

BENEFIT ADDITION RIDER

POLICY NUMBER H- 3236167 INSURED Vincenzo Mazzamuta

This Benefit Addition Rider and any rider(s) named below are added to this policy. They are made part of the policy based on:

(1) The application for them.

(2) The payment of the amounts shown in (a) and (b) below:

(a) $ -0- payable as of 2-28-94 This is the effective date of this Benefit Addition Rider and the rider(s) named below.

(b) $ 1609.85 payable at C.O.M intervals, beginning as of 2-28-94, subject to the terms of the policy.

ADDITIONAL BENEFIT	PREMIUM AMOUNT
Additional Monthly Benefit of $1000 - added.	$ 453.30

Incontestability or Time Limit on Certain Defenses Any Incontestability or Time Limit on Certain Defenses provision of the policy does not apply to this Benefit Addition Rider and the rider(s) named above. Instead, the Incontestability of Rider provision in the rider(s) named above will apply.

Effective Date of this Rider This Benefit Addition Rider and any rider(s) named above will not take effect as of the policy date. Instead, they will take effect on this rider's effective date, shown above. The additional benefits provided will not apply to any claim which results from an injury which occurs or a sickness which first manifests itself before the effective date of this rider.

Change of Entire Contract Provision The Entire Contract provision of the policy is changed to include this statement.

"The attached copy of any application for additional benefits is part of the entire contract."

NEW YORK LIFE INSURANCE COMPANY

Albert T Kane
Secretary

[signature]
President

NYLCL00256

Countersignature

Countersigned by ______________________
Licensed Resident Agent if required by statute or regulation

86-212

PT702785

APPLICATION PART I TO NEW YORK LIFE INSURANCE COMPANY (Continued)

6. Answer if APPLICANT ☐ and/or OWNER ☐ (check one or both, as appropriate) is not Proposed Insured.

(a) Name _____ (b) Soc. Sec. No. or Emp. ID No. _____

(c) Residence Address _____ Zip _____

(d) Business Address _____ Zip _____

(e) Mailing Address Residence ☐ Business ☐ Other _____

(f) Date of Birth (or date of incorporation, if a corporation) _____

7. (a) PLAN OF INSURANCE AND OPTIONAL BENEFITS

DISABILITY INCOME

PRIMARY PLAN
Monthly Benefit $ 3000 SIS Rider $_____, COLB 5% ☒ 7½% ☐ IPO 3 UNI
Elim. Per. (days) 30 ☐ 60 ☐ 90 ☒ 180 ☐ 365 ☐ 730 ☐; Premiums Level ☒ or Step Rate ☐
Benefit Term 2 years ☐ 5 years ☐ To Age 65 ☒ To Age 67 ☐ Lifetime ☐

SECONDARY PLAN
Monthly Benefit $_____ Elim Per (days) 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730
Benefit Term 2 years ☐ 5 years ☐ To Age 65 ☐ To Age 67 ☐ Lifetime ☐

ARDI
Monthly Benefit $_____ Elim Per (days) 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730
Benefit Term To Age 65 ☐ To Age 67 ☐ Lifetime ☐

RIDERS (Apply to Primary Plan, Secondary Plan, and ARDI) Residual ☒ Unrestricted Own Occ ☒ Other _____

Exercise Automatic Benefit Increase options? (Applies only to Primary Plan and Secondary Plan) Yes ☒ No ☐

OVERHEAD EXPENSE 12 x ☐ 24 x ☐ IPO _____ Units
Max. Monthly Benefit $_____ Elim Per (days) 30 ☐ 60 ☐ 90 ☐

DISABILITY BUY-OUT Elim Per (months) 12 ☐ 24 ☐ 36 ☐ IMB _____ Units
Buy-Out Benefit $_____

KEY EMPLOYEE DISABILITY Elim Per (days) 30 ☐ 60 ☐ 90 ☐ IPO _____ Units
Monthly Benefit $_____

Complete (b) and (c) below if the Proposed Insured is a non-owner employee. If the Proposed Insured owns any portion of t business, complete (c) below and the Supplement to Application Part I.

(b) EARNED INCOME — Earned income consists of wages, commissions and other amounts received for personal services, reportable for personal federal income tax purposes, after deducting normal business expenses.

(i) What is the Proposed Insured's earned income at the current annual rate? $_____

(ii) What was the Proposed Insured's earned income for the prior calendar year? $_____

(iii) Does the Proposed Insured ever receive more than 30% of his or her annual earned income in a single month?
Yes ☐ No ☐ If "Yes", explain in question 12.

NYLCL00254

(c) UNEARNED INCOME AND NET WORTH

(i) What is the Proposed Insured's annual unearned income (include interest, dividends, rent, etc.)?
None ☒ Other $_____

(ii) Is the Proposed Insured's net worth (assets minus liabilities) over $4,000,000? No ☒ Yes ☐
If "yes" complete section 2 of Supplement to Application Part I.

PT 702785

APPLICATION PART I TO NEW YORK LIFE INSURANCE COMPANY (Continued)

(d) OTHER INCOME PROTECTION COVERAGE ON THE PROPOSED INSURED

(i) Will the employer continue salary in the event of an inability to work due to disability? Yes ☐ No ☒

If "Yes", salary of $_____ will be continued for _____ months.

(ii) List below other income coverage in force or pending on the Proposed Insured. Indicate type: (1) Individual (2) Association (3) Group (4) Employer Sick Pay (5) Overhead (6) Buy-Out.

Company or Source	Type 1,2,3,4, 5 or 6	Policy or Certificate #	Effective Date	Monthly Income	Elim. Per.	Ben. Term	Will this coverage be replaced?	Date coverage will be terminated?
none				$			Yes ☐ No ☐	
				$			Yes ☐ No ☐	
				$			Yes ☐ No ☐	
				$			Yes ☐ No ☐	

(e) PREMIUM PAYER

(i) If employer is to pay all or part of the premium, indicate the percentage: _____%

8. PREMIUM MODE Annual ☐ Semiannual ☑ Quarterly ☐ C-O-M ☐ Nyl-A-Plan ☐
CHECK IF LIST BILLING APPLIES ☐

9. POLICY DATE _____, 19____ if no date is specified, the policy date is: the later date of Parts I and II if cash is paid with this application; or the date of issue, if cash is not paid. If cash is not paid and the policy has not been issued by the date specified, the policy date will be the date of issue.

10. IF AMENDING APPLICATION PREVIOUSLY SUBMITTED: Since the date of the application for the policy (including any Part II), has the Proposed Insured:

(a) been admitted to a hospital, sanitarium or other medical facility? Yes ☐ No ☒ If "Yes", submit a new application Part II.

(b) had any illness, injury, or consulted any physician or practitioner for any reason, including routine checkup examination?
Yes ☐ No ☒ If "Yes", give full details _____

11. (a) IF AMOUNT OF BENEFIT IS BEING INCREASED UNDER AN OPTION: (IPO, IMB)
Amount of Increase $_____ (b) Option Date _____, 19____ (c) Scheduled ☐ or Alternate (Special) ☐
If Alternate (Special) Option Date, give: Date of marriage ☐, Birth ☐ or Adoption ☐ Mo._____ Day_____ Yr._____

(b) IF ARDI IS BEING CONVERTED
Amount of coverage being converted $_____

12. ADDITIONAL DETAILS AND SPECIAL REQUESTS (incl. Question Number, where applicable).
Ques. No.

Please Change policy # H3 232 167 as follows -
Increase monthly benefit to $3000.00 ; waiting period to be 90 days, 3 IPO units, 5% COLA to age 65, Residual Rider w/ unrestricted own occupation
Premium mode to be Semi-annual
Please Refer to policy # 44 904 932 for blood requirements
Please issue policy NON-Smoker Rates

NYLCL00251

ACKNOWLEDGEMENT

I have been given a copy of "Information Practices Related to Underwriting Your Application" which tells how New York Life Insurance Company and New York Life Insurance and Annuity Corporation obtain and use data about me. It includes the notice required by the state and federal Fair [illegible]

4U2105

DISABILITY INCOME INSURANCE APPLICATION PART I

NEW YORK LIFE INSURANCE COMPANY 51 Madison Ave., New York, N.Y. 10010

I/We hereby apply for insurance based on the following representations:

If not an application for a New Policy check one:

- Add Rider to Policy No. ☐
- ✓ Change in Policy No. 43 236 167
- Application to Reinstate Policy No. ☐
- ☐ Converting ARDI in Policy No.
- ☐ Amend Application No.
- ☐ Exercising Option in Policy No.
- ☐ Upgrade Policy No.

1. (a) PROPOSED INSURED VINCENZO MAZZANUTO (b) Soc. Sec. No. 196-56-5744 (c) Sex M ☒ F ☐
(d) Date of Birth Mo. 05 Day 25 Year 1955 (e) Place of Birth State (f) Country Italy
(g) ADDRESS (Complete street address including any apt. no. and Zip; do not only give P.O. Box)
(i) Residence 201 Limestone Rd Zip 17013 (iv) Time at Address 6 Yrs. Mos.
Carlisle, PA (v) Mail Address
(ii) Telephone number(s) and best time to call Res. (717) 243-0383 A.M. 9:00 P.M. Res. ☒ Bus. ☐
(iii) Bus. (717) 249-6417 A.M. P.M. 2:30 If Proposed Insured cannot be reached by telephone, explain reason
(h) Has the Proposed Insured smoked cigarettes in the last 12 months? Yes ☐ No ☒

2. (a) OCCUPATION President of 50's First Class Restaurant
(i) Exact duties, including percentage of time spent performing any manual or supervisory duties and traveling
Executive, office duties only
(b) Does the proposed Insured have any other occupations? Yes ☐ No ☒ If "Yes", describe
Check if a Federal Govt. Employee ☐
(c) EMPLOYER Vinny's Restaurant Inc. Check if a Municipal Govt. Employee ☐
Address of Employer 330 South Hanover St (ii) Time with Employer
Carlisle, PA 17013 12 Yrs. Mos.
(d) Former Employer (within 2 years)
(i) Address of Former Employer
(e) Does the Proposed Insured own any portion of the business? Yes ☒ No ☐ If "Yes", complete the Supplement to Application Part I.

	Yes	No
3. (a) Within the last 2 years, has the Proposed Insured engaged in: motorized racing, scuba or sky diving, ballooning, hang-gliding, ultra-light flying, stunt flying, mountain climbing, or rodeo riding, or does he or she intend to do so? If "Yes", complete Form 7663.	☐	☒
(b) been convicted for 3 or more motor vehicle moving violations or been charged with driving under the influence of alcohol or drugs? If "Yes", complete CPHQ-Form 17480.	☐	☒
(c) been declined for issue, renewal or reinstatement, rated or charged an extra premium for any type of Life or Health Insurance? If "Yes", give company and reasons, if known, in question 12.	☐	☒
4. If cash is to be paid with this application, has the Proposed Insured, within the last 2 years (a) been medically treated in, or been advised to seek medical treatment in a hospital, sanitarium or clinic other than for childbirth?	☐	☒
(b) been medically diagnosed as having or received medical treatment for heart trouble, cancer (other than skin cancer), AIDS or AIDS-related complex (ARC), elevated blood pressure requiring medication, had any abnormal blood test results or had an electrocardiogram made for any cause other than a routine physical examination?	☐	☒
(c) had an unexplained weight loss or swollen glands, recurring diarrhea, fever or infection, persistent cough, insomnia or thrush?	☐	☒
If "Yes" to either (a), (b) or (c) above, cash may not be paid. Also give details in question 12.		
5. Is it agreed that cash will be received subject to the terms of the attached receipt, that no coverage will be provided under the receipt unless all conditions to coverage are met, and that any such coverage will be temporary and limited in amount? If "No", cash may not be paid	☒	☐

CASH PAID $ 0

NYLSP00002

Accident and Sickness Department.

NEW YORK LIFE INSURANCE COMPANY

New York, New York 10010

RIDER CHANGING POLICY DATE

Attached to and made a part of Policy Number H3 236 167,

Vincenzo Mazzamuto, the Insured.

In accordance with the applicant's written request, the policy date stated on the first page of this policy is hereby changed to August 28, 19 93.

NEW YORK LIFE INSURANCE COMPANY

Edmund A. Harmely
Secretary

Countersigned by _____
Office Manager
(for Office Manager)

NYLSP00012

55-106 A.S.

PT/UZ/bb

APPLICATION PART I TO NEW YORK LIFE INSURANCE COMPANY (Continued)

6. Answer if APPLICANT ☐ and/or OWNER ☐ (check one or both, as appropriate) is not Proposed Insured.

(a) Name _____ (b) Soc. Sec. No. or Emp. ID No. _____

(c) Residence Address _____ Zip _____

(d) Business Address _____ Zip _____

(e) Mailing Address Residence ☐ Business ☐ Other _____

(f) Date of Birth (or date of incorporation, if a corporation) _____

7. (a) PLAN OF INSURANCE AND OPTIONAL BENEFITS

DISABILITY INCOME

PRIMARY PLAN
Monthly Benefit $ 2,000 SIS Rider $ _____ COLB 5% ☑ 7½% ☐ IPO 3 UNITS
Elim. Per. (days) 30 ☐ 60 ☐ 90 ☐ 180 ☑ 365 ☐ 730 ☐; Premiums Level ☑ or Step Rate ☐
Benefit Term 2 years ☐ 5 years ☐ To Age 65 ☑ To Age 67 ☐ Lifetime ☐

SECONDARY PLAN
Monthly Benefit $ _____ Elim Per (days) 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730 ☐
Benefit Term 2 years ☐ 5 years ☐ To Age 65 ☐ To Age 67 ☐ Lifetime ☐

ARDI
Monthly Benefit $ _____ Elim Per (days) 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730 ☐
Benefit Term To Age 65 ☐ To Age 67 ☐ Lifetime ☐

RIDERS (Apply to Primary Plan, Secondary Plan, and ARDI) Residual ☑ Unrestricted Own Occ ☑ Other _____

Exercise Automatic Benefit Increase options? (Applies only to Primary Plan and Secondary Plan) Yes ☑ No ☐

OVERHEAD EXPENSE 12 x ☐ 24 x ☐ IPO _____ Units
Max. Monthly Benefit $ _____ Elim Per (days) 30 ☐ 60 ☐ 90 ☐

DISABILITY BUY-OUT Elim Per (months) 12 ☐ 24 ☐ 36 ☐ IMB _____ Units
Buy-Out Benefit $ _____

KEY EMPLOYEE DISABILITY Elim Per (days) 30 ☐ 60 ☐ 90 ☐ IPO _____ Units
Monthly Benefit $ _____

Complete (b) and (c) below if the Proposed Insured is a non-owner employee. If the Proposed Insured owns any portion of the business, complete (c) below and the Supplement to Application Part I.

b) EARNED INCOME — Earned income consists of wages, commissions and other amounts received for personal services, as reportable for personal federal income tax purposes, after deducting normal business expenses.

(i) What is the Proposed Insured's earned income at the current annual rate? $ _____

(ii) What was the Proposed Insured's earned income for the prior calendar year? $ _____

(iii) Does the Proposed Insured ever receive more than 30% of his or her annual earned income in a single month?
Yes ☐ No ☐ If "Yes", explain in question 12.

c) UNEARNED INCOME AND NET WORTH

(i) What is the Proposed Insured's annual unearned income (include interest, dividends, rent, etc.)?
None ☐ Other $ _____

(ii) Is the Proposed Insured's net worth (assets minus liabilities) over $4,000,000? No ☐ Yes ☐
If "yes" complete section 2 of Supplement to Application Part I.

NYLSP00013

NON-MED.

☒ NEW YORK LIFE INSURANCE COMPANY
☐ NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (A Delaware Corp.)
51 Madison Avenue, New York, N.Y. 10010

Policy Number (if known)?

Answers to Insurer forming Part II of Application for Insurance. (Please print or type.)

Full information on all persons proposed for coverage in Question 1. (Use Question 11 for all details requested in Questions 2-11.)

1. a. PROPOSED INSURED? Vincenzo Mazzamuto Height? 5 ft. 6 in.; Weight? 195 lbs.
b. SPOUSE, if proposed for coverage? Height? ft. in.; Weight? lbs.
c. CHILDREN, if proposed for coverage (give full names)?

2. Personal physicians (give consultation details in Ques. 11) Name? Address and Phone No.? Date last consulted?
a. For Proposed Insured Masland Medical Associates 220 Wilson St. Ste 109 1 month ago
b. For Spouse named in Ques. 1 (717)249-1929 Carlisle, PA 17013

Answer Questions 3-11, so far as known, for all persons in Ques. 1. (If "Yes" to Ques. 6, submit CPHQ Form 17480 for that person, and give name in Ques. 11.)

3. In last 10 years, has such person consulted a physician or practitioner for, been treated for, had, or been informed that he or she had	Yes	No
a. heart trouble, angina, stroke, murmur or irregular pulse?	☐	☒ a
b. diabetes or elevated blood sugar?	☐	☒ b
c. chronic bronchitis, emphysema, asthma or other lung disorder?	☐	☒ c
d. cancer, tumor, lymphoma; lupus or collagen disorder; rheumatoid arthritis or muscular disease?	☐	☒ d
e. pancreatitis; urine sugar; hepatitis; cirrhosis or liver trouble?	☐	☒ e
f. AIDS, AIDS-related complex (ARC), or other immune deficiency?	☐	☒ f
g. elevated blood pressure; thrombophlebitis, embolism or other circulatory disorder; kidney disease; albumin or blood in urine?	☐	☒ g
h. ulcerative colitis, ileitis or other chronic intestinal disorder?	☐	☒ h
i. seizures, dizziness or fainting; other nervous system disorder?	☐	☒ i
j. anemia, thyroid or other blood or gland disorder?	☐	☒ j
k. ulcer; hernia; varicose veins; gall bladder disorder; kidney stones?	☐	☒ k
l. back, spine, joint or bone disorder; eye, ear or skin disorder?	☐	☒ l
m. (if a male) disorder of prostate or reproductive organs? (if a female) disorder of pelvic organs, breasts, menses or pregnancy, or is she now pregnant?	☐	☒ m
4. Is any such person now taking prescription medication?	☐	☒

5. In last 2 years, has any such person had any of the following:	Yes	No
a. unexplained weight loss or swollen glands; recurring diarrhea, fever or infection; persistent cough, pneumonia, or thrush?	☐	☒ a
b. chest discomfort, edema, transient visual loss, muscle weakness, shortness of breath, or internal bleeding?	☐	☒ b
6. In last 10 years, has any such person been counselled, treated or hospitalized for any psychiatric, emotional or mental health condition, or for the use of alcohol or drugs? (If yes, submit CPHQ.)	☐	☒
7. Other than as stated, has any such person during past 2 years had a. treatment or surgery in a hospital or other facility?	☐	☒ a
b. an electrocardiogram, x-ray or other diagnostic test, or an examination for checkup or other purpose?	☐	☒ b
c. advice about any treatment, surgery or diagnostic testing which was not completed?	☐	☒ c
8. Has any such person, for physical or mental health reasons, ever received disability benefits, compensation or pension; or been rejected for, or discharged from, military service?	☐	☒
9. Any history of angina, heart trouble or stroke before age 60 among natural parents, brothers or sisters of any such person? If "Yes", give relationship, age at onset and subsequent history.	☒	☐
10. Has Prop. Insured smoked any cigarettes in the past 12 months?	☐	☒

11. GIVE FULL DETAILS FOR EACH "YES" ANSWER IN QUESTIONS 3-5, 7-9, AND LAST CONSULTATION WITH PERSONAL PHYSICIAN IN PAST 2 YEARS

a. Ques. No.	b. Name of Person to whom "Yes" applies	c. Reason – nature and severity of condition? (Include frequency, treatment, medication, surgery and results.)	d. Onset? Mo. Yr.	e. Recovery? Mo. Yr.	f. Names and Addresses of Physicians, Hospitals or Medical Facilities?
9	Father	Stroke prior to age 60			
		PT last consulted Dr Robinson injury - fully recovered	4/93	See Knee - no further treatment needed	

NYLAP00008

THE UNDERSIGNED DECLARE THAT to the best of their knowledge and belief, all answers given in this Part II are correctly recorded, complete and true.

Dated at Carlisle, PA on 6/3, 19 93

I certify I have truly and accurately recorded all answers given to me.

Witnessed by Johnston Agent

Vincenzo Mazzamuto
Signature of Proposed Insured

Signature of Spouse, if proposed for coverage;
Signature of Parent or Guardian, if Prop. Insured under 14 years 6 months

No. 144

H. I. Policy No. H3236167

HEALTH INSURANCE MEMORANDUM

This Memo. must be attached OVER all the papers of the Application to which it refers, and must not be detached therefrom.

DATE | NAME OF INSURED (PRINT) Vincenzo Mazzamuto | DRUM DATES

DATE		DRUM DATES
1/24	WS44904932 (Home) (from 6/93)	
	Please be advised that the C100 rider is not available at our age 24.	
1/26	WS44904932	
1/26	PHU	
1/27	BPU ... on file	
	PCC - Ok to add 1000 AMT, change to 90 E.P. and mode to Semi-Annual	
1/31/94	H14 86-209 121V sent.	
2/16		
2/16	PCC - Please change to non smoker rates effective from start.	PCC

H185174

NYLAP00013

1. Based on occupational duties of _____ any policy issued will be, _____ at best, occupational class _____. Advise if acceptable. Information from IR.

2. Based on annual earned/unearned income of _____ any policy issued will be at best for _____ and SIS rider _____. We will consider if furnished with factual proofs of earned (net) income.

3. Based on annual earned/unearned income of _____ and other coverage in force with _____, any policy issued will be at best _____ and SIS _____. Will reconsider if furnished with factual proofs of earned (net) income.

4. We have reason to believe that the proposed insured has a monthly income policy in force/pending with _____. Advise amount, BENEFIT PERIOD & status of policy.

5. Based on MIB information, we have reason to believe that the proposed insured may not have given us full details in answer to questions of Part II. Please secure a new non-medical Part II with special attention to such questions 3L _____.

6. Based on history of _____, any policy issued will require a _____ Rider. We can consider on a standard basis with a _____ day waiting period. Advise if acceptable.

7. Based on history of _____, any policy issued will require a _____ special class extra premium. We can consider on a standard basis with a _____day waiting period. Advise if acceptable.

8. Based on history of _____, any policy issued will include a rider and/or a special class_____ extra premium on _____. As this is a replacement, advise if acceptable.

9. Based on occupational class of _____ we cannot offer Plan _____. Can consider for _____. Advise if acceptable.

10. Based on _____ history, any policy issued will require a _____ Rider with a _____ day waiting period. All other conditions will have _____ day waiting period.

11. We still have not received SRC documents. Please advise when they will be forwarded.

12. Because Nylic group disability benefits, which proposed will be eligible for integrate with Social Security, it is to proposed insured's benefit to apply for total amount in base policy. If desired, we can consider as applied for. Please advise.

13. Advise proposed insured's residency status, years in U.S. and does proposed insured intend to remain in the U.S. permanently.

14. It is difficult for us to accept an application on an individual at this age who has never seen a physician. Please advise name of Attending Physician, dates and reasons consulted.

AMENDMENT

NAME: MAZZAMUTO

NUMBER: H3 236 167

NOTE: This requirement must not be changed or modified in any way, but remain as made out by the Home Office

APPLICATION DATED: JUNE 3, 1993

The NEW YORK LIFE INSURANCE COMPANY will please accept the following answers in lieu of the answers to the corresponding questions in my application for insurance dated as indicated above.

QUESTION No. 7 (A)	DISABILITY INCOME	PRIMARY PLAN Monthly Benefit $2000 SIS Rider $ _____, COLB 5% ☒ 7½% ☐ IPO ___ UNITS Elim. Per. (days) 30 ☐ 60 ☐ 90 ☐ 180 ☒ 365 ☐ 730 ☐ Benefit Term: 2 years ☐ 5 years ☐ To Age 65 ☒ To Age 67 ☐ Lifetime ☐ Premiums: Level ☒ or Step Rate ☐
		SECONDARY PLAN Monthly Benefit $ _____ Elim. Per. (days) 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730 ☐ Benefit Term: 2 years ☐ 5 years ☐ To Age 65 ☐ To Age 67 ☐ Lifetime ☐
		ARDI Monthly Benefit $ _____ Elim. Per. (days) 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 ☐ 730 ☐ Benefit Term: To Age 65 ☐ To Age 67 ☐ Lifetime ☐
		RIDERS: Residual ☒ Unrestricted Own Occ ☐ Other _____
		Exercise Automatic Benefit Increase options? Yes ☒ No ☐
	OVERHEAD EXPENSE	Max. Monthly Benefit $ _____ 12 X ☐ 24 X ☐ IPO ___ UNITS Elim Per (days) 30 ☐ 60 ☐ 90 ☐
	DISABILITY BUY-OUT	Buy-Out Benefit $ _____ IMB ___ UNITS Elim Per (months) 12 ☐ 24 ☐ 36 ☐
	KEY EMPLOYEE	Monthly Benefit $ _____ IPO ___ UNITS Elim Per (days) 30 ☐ 60 ☐ 90 ☐
QUESTION No. 3L		OF PART II SHOULD BE ANSWERED INTENDED TO BE YES.

and I hereby agree that the above answers shall form a part of my said application for insurance, the agreement in which I hereby renew and confirm, and shall apply to any policy issued thereon.

Dated 8/28, 19 93 _____ Proposed Insured

Witness _____ _____ Applicant

Forwarded to the Central Records Division from CONSTITUTION General Office

8/30, 19 93

256-B 1-89 Printed in U.S.A.

NYLAP00043

I have been given of "Information Practices Related to Und ur Application" which tells how New Yor surance Company and New York Life Insurance and Annuity Corporation obtain and use data about me. It includes the notice by the state and federal Fair Credit Reporting Acts and a description of MIB, Inc. (Medical Information Bureau).

AUTHORIZATION

(In this Authorization, "the Insurer" means New York Life Insurance Company or New York Life Insurance and Annuity Corporatio whichever applies.)

In order to see if (and on what basis) I qualify for insurance or for the benefits which that insurance may provide, I authori the following:

MEDICAL INFORMATION Physicians or practitioners; hospitals; medical or medically related facilities; laboratories; insurance cor panies; or MIB may give to the Insurer (or any consumer reporting agency acting in its behalf) and to any of its reinsurers da and copies of records that they may have about my physical and mental health. The data and records may include important histor findings, diagnoses and treatment.

OTHER UNDERWRITING INFORMATION MIB and other insurance companies may give to the Insurer and to any of its reinsure data about: my driving record; any criminal activity or association; hazardous sport or aviation activity; use of alcohol or drugs; a claim of eligibility for disability income benefits; and other applications for insurance.

EXAMINATIONS AND TESTS The Insurer may obtain physical examinations or medical tests deemed necessary to underwrite n application. These tests (where permitted by law) may include, but are not limited to, electrocardiograms, chest x-rays, and tes of blood and urine to determine, among other things, exposure to causative agents of disease (for example, exposure to the AID virus) and the presence of drugs. However, a separate notification/authorization form will be provided with respect to testing for t AIDS virus.

INVESTIGATIVE CONSUMER REPORT The Insurer may obtain an investigative consumer report and may give the consumer reportin agency information concerning the amount and type of my coverage and my use, if any, of tobacco. The report may add to or confir the types of data mentioned above. It may also contain data about: my identity; age; residence; marital status; past and present jol (including work duties); economic conditions; driving record; personal and business reputation in the community; and mode of livin but will not include any information relating directly or indirectly to sexual orientation.

IDENTIFICATION To obtain the data described above, the Insurer may give my name, address, and date, and place of birth to t above persons or organizations.

RELEASE OF INFORMATION TO OTHERS When necessary, the Insurer may give data about me that affects my insurability to: i subsidiaries; its affiliates; its parent company; its agents and their staffs; its reinsurers; and the Insurer and its reinsurers may gi such data to MIB. However, this will not be done in connection with information relating to the AIDS virus.

I also authorize the release of these same types of data about any of my children who are to be insured.

This authorization shall be valid for 30 months from the date shown below. A photocopy of it shall be as valid as the origin

In giving this authorization, I release the above parties from all liability in the securing and use of the above underwriting dat

I know that a copy of this form is in the Insurer's statement on "Information Practices Related to Underwriting Your Application

Date 6/3 ,19 93

Witness Agent

Signature of Proposed Insured (Annuit

Signature of Spouse, if proposed for coverage; or
Signature of Parent or Guardian, if Proposed Insured (Annuitant) is Under 14 years 6 months

NYLCL00355

17852 7-91

Servizio A.

POLICY RECEIPT

NEW YORK LIFE INSURANCE COMPANY

☐ NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION
(A Delaware Corporation)

51 MADISON AVENUE, NEW YORK, N.Y. 10010

Insured/Annuitant Vincenzo Mazzamuto Policy Number 43 236 167

I hereby acknowledge receipt of the above numbered policy, which includes a copy of my signed application.

Additional Information for Whole Life, Modified Premium Whole Life, and Survivorship Whole Life Policies

Dividends shown in the illustrations for this policy and the values based on those dividends reflect New York Life's current dividend scale, which is not guaranteed nor an estimate of future dividends that will be paid. Because of possible changes in the economy and the unpredictability of the future, dividends and the values based on dividends may be higher or lower than illustrated. If the illustration shows dividend values being used to pay premiums, or if it shows dividend values being withdrawn, a change in the dividend scale, additional withdrawals, or exercising a policy loan can cause the amount of cash premium payments or the amount available for withdrawal to vary.

I have been shown an alternate dividend illustration which shows values based on a reduction in dividends below the current dividend scale. That illustration does not reflect any planned actions by New York Life and is only an example of how lower dividends could affect policy values. Dividends actually paid may be higher or lower than shown in the illustrations.

I have reviewed the above information and the alternate illustration, along with Form 11939 (How to Read a Life Insurance Illustration), and understand that dividends are not guaranteed and illustrated dividends are not an estimate of future dividends that will be paid.

Signature of Owner X Vincenzo Mazzamuto Date 8/28/93

Signature of Agent Salvatore A Bruno

NOTE: Form 11939 must be given to the policyowner with the illustrations.

● 20673 12/92 GENERAL OFFICE COPY 206731

NYLCL00353

(Submit .....) N. Vincenzo Mazza

OCCUPATION TITLE: President

OCCUPATION DUTIES: Executive, office duties only

BASIC OCCUPATIONAL CLASS 2A FINAL OCCUPATIONAL CLASS 3A

AGENT NAME: Salvatore Ferrigno

GENERAL OFFICE: Constitution Co.

POLICY NUMBER:

	AGENT'S USE	HOME OFFICE USE
ANNUAL EARNED INCOME AFTER BUSINESS EXPENSES	$53,039	$
BUSINESS ALLOWANCE	$ 52,43	$
CAR ALLOWANCE	$ 6,000	$
OTHER (explain)	$	$
TOTAL =	$64,282	$
AGE	38	
YEARS OWNING PRESENT BUSINESS	13	
PERCENTAGE OF OWNERSHIP	100%	

INITIAL CLASS ____
SCHEDULE CLASS ____

CIRCLE ONE
ISSUED
FILED
DECLINED

BUSINESS OWNERS' FACTORS CHART

(Appropriate Categories Should Be Circled)

ADJUSTED INCOME	AGE 18 - 28 (YEARS IN BUSINESS AS OWNER: 1 / 2-8 / 9+)	AGE 29 - 33 (YEARS IN BUSINESS AS OWNER: 1 / 2-8 / 9+)	AGE 34 - 39 (YEARS IN BUSINESS AS OWNER: 1 / 2-4 / 5-8 / 9+)	AGE 40 - 54 (YEARS IN BUSINESS AS OWNER: 1 / 2-4 / 5-8 / 9+)	AGE 55+ (YEARS IN BUSINESS AS OWNER: 1 / 2-4 / 5-8 / 9+)
16K - 24,999	NC NC NC	NC NC NC	NC NC NC NC	NC NC NC NC	NC NC NC NC
25K - 34,999	NC NC NC	NC NC NC	NC NC NC NC	NC NC NC UP 1	NC NC UP 1 UP 1
35K - 49,999	NC NC NC	NC NC NC	NC NC NC NC	NC NC NC UP 1	NC NC UP 1 UP 1
50K - 74,999	NC NC NC	NC NC NC	NC NC NC UP 1	NC NC NC UP 1	NC UP 1 UP 1 UP 1
75K - 119,999	NC NC NC	NC NC NC	NC NC NC UP 1	NC NC UP 1 UP 1	NC UP 1 UP 1 UP 2
120K +	NC NC NC	NC NC UP 1	NC NC UP 1 UP 1	NC UP 1 UP 1 UP 1	NC UP 1 UP 1 UP 2

NC: NO CHANGE IN OCC CLASSIFICATION
UP: INDICATES OCC CLASSIFICATION UPGRADED ONE OR TWO CLASSES i.e., 2A may become 3A or 4A

NYLCL00356

H20140 (591)

If not an application for a N ...os -heck one:

- ☐ Add Rider to Policy No.
- ☐ Change in Policy No.
- ☐ Application to Reinstate Policy No.
- ☐ Convertir ...RD... Policy No.
- ☐ Amend A... No.
- ☐ Exercising Op...n in Policy No.
- ☐ Upgrade Policy No.

1. (a) PROPOSED INSURED Vincenzo Mazzamuto (b) Soc. Sec. No. 196-56-5744 (c) Sex M ☑ F ☐

(d) Date of Birth Mo. 05 Day 25 Year 1955 (e) Place of Birth State _____ (f) Country Italy

(g) ADDRESS (Complete street address including any apt. no. and Zip; do not only give P.O. Box) (iv) Time at Address

(i) Residence 501 Limestone Rd Zip 17013 6 Yrs. ____ M

Carlisle, PA (v) Mail Address

(ii) Telephone number(s) and best time to call Res. (717) 243-0383 A.M. 9:00 P.M. ____ Res. ☑ Bus. ☐

(iii) Bus. (717) 249-6417 A.M. ____ P.M. 2:00 If Proposed Insured cannot be reached by telephone, explain reas

(h) Has the Proposed Insured smoked cigarettes in the last 12 months? Yes ☐ No ☑

2. (a) OCCUPATION President of East Coss Restaurant

(i) Exact duties, including percentage of time spent performing any manual or supervisory duties and traveling

Executive, office duties only

(b) Does the proposed Insured have any other occupations? Yes ☐ No ☑ If "Yes", describe

Check if a Federal Govt. Employee

(c) EMPLOYER Vinny's Restaurant Inc. Check if a Municipal Govt. Employee

(i) Address of Employer 330 South Hanover St (ii) Time with Employ

Carlisle, PA 17013 13 Yrs. ____ M

(d) Former Employer (within 2 years)

(i) Address of Former Employer

(e) Does the Proposed Insured own any portion of the business? Yes ☑ No ☐ If "Yes", complete the Supplement to Applica Part I.

3. (a) Within the last 2 years, has the Proposed Insured engaged in: motorized racing, scuba or sky diving, ballooning, hang-gliding, ultra-light flying, stunt flying, mountain climbing, or rodeo riding, or does he or she intend to do so? If "Yes", complete Form 7663. Yes ☐ N ☐

(b) been convicted for 3 or more motor vehicle moving violations or been charged with driving under the influence of alcohol or drugs? If "Yes", complete CPHQ-Form 17480. ☐

(c) been declined for issue, renewal or reinstatement, rated or charged an extra premium for any type of Life or Health Insurance? If "Yes", give company and reasons, if known, in question 12. ☐

4. If cash is to be paid with this application, has the Proposed Insured, within the last 2 years

(a) been medically treated in, or been advised to seek medical treatment in a hospital, sanitarium or clinic other than for childbirth? ☐

(b) been medically diagnosed as having or received medical treatment for heart trouble, cancer (other than skin cancer), AIDS or AIDS-related complex (ARC), elevated blood pressure requiring medication, had any abnormal blood test results or had an electrocardiogram made for any cause other than a routine physical examination? ☐

had an unexplained weight loss or swollen glands, recurring diarrhea, fever or infection, persistent cough, insomnia or thrush? ☐

"Yes" to either (a), (b) or (c) above, cash may not be paid. Also give details in question 12.

...reed that cash will be received subject to the terms of the attached receipt, that no coverage will be ...d under the receipt unless all conditions to coverage are met, and that any such coverage will be ...ry and limited in amount? If "No", cash may not be paid ☑

CASH PAID $ 0

NYLCL00357

O TI other form nd an lease.

916

916

(Check one)

CORPORATION ☐ PARTNERSHIP ☐ "S" CORPORATION ☒ SOLE PROPRIETORSHIP ☐

c.) NUMBER OF EMPLOYEES
PRIOR TO THE ONSET OF YOUR CLAIMED DISABILITY: FULL-TIME 7 PART-TIME 6
CURRENTLY: FULL-TIME 6 PART-TIME 4

d.) WITHIN THE LAST 6 MONTHS, HAVE YOU HIRED ANY EMPLOYEES TO PERFORM ANY OF YOUR JOB DUTIES? YES ☐ NO ☐

e.) IS THE BUSINESS OPERATING AT THIS TIME? YES ☒ NO ☐

f.) HAS THERE BEEN ANY CHANGE OF OWNERSHIP OF THE BUSINESS IN THE LAST 6 MONTHS? YES ☐ NO ☒

g.) DO YOU HAVE PLANS FOR, OR ARE YOU CONTEMPLATING THE SALE OF YOUR SHARE OF THIS BUSINESS? YES ☒ NO ☐

.NY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN .PPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR 'HE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE .CT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

DECLARATION AND SIGNATURE

declare that the answers provided on each page of this form and any attachments are complete and true to the best of my knowledge nd belief. I understand that the Company reserves the right to require further information in order to evaluate my claim.

11-22-00
'ate

Signature of Insured (Insured or Insured's authorized representative)

Relationship if other than Insured

2027 10/98

CLAIM DEPARTMENT
PHONE MEMO

CLAIMANT: Vincenzo Mazzamuto

POLICY/CLAIM # 13-h3236167-002

PHONE NUMBER:

CALL IN

CALL OUT

PERSON CALLING/CALLED

Insured

CONVERSATION: Called insured to go over claim form. Asked him to explain to me what happened. He had a heart attack in July and when they were putting him into the ambulance, his back snapped. He indicated that he has had back problems for years and this reinjured an injury that was already there. He gets injections for his back. He said that the back problems never went away but this just made him worse. I asked about his heart. Is that better. He said that it was. He attended cardiac rehab. He said that he thinks that that is a "rip off" because they barely let you move. He walks on the treadmill every day at home. He thinks that what is mostly keeping him off of work now is his back. His legs are numb. He said that he has a letter from his dr. about his back but his attorney's office advised him not to send that because he is claiming his heart problem. I told him that that letter would be beneficial for us to have because most of his symptoms and complaints are due to his back and not his heart. He asked me to call his attorney's office and speak with Melissa and she will send it to me. I told him that I would do that. I asked him about his job. What are your duties? His duties are mostly managerial. He does the books, orders food, writes the checks, etc. Had his workers do everything----cook, wait tables, etc. He would very rarely help out unless someone didn't come in to work then he would help cook or help with the tables. He said that that rarely happened though. What has happened to business now? He said that it is still open. His wife and son are running the business. His son quit school to help out. He is going to apply to a college closer to home. He said that he wanted to sell the restaurant but they have kids to take care of/support. I asked if he thought his job was stressful. He said that he thinks he is just a very nervous person. He thinks that maybe he has had too many years in the business. He said that he is from Italy and doesn't know English as well as other people and therefore, feels that he can't learn anymore. Gets frustrated. He is on medication for stress. He said that he doesn't know if he will ever return to work. I did indicate that we would obtain all of his medical records from all treating physicians to make a determination on his claim. I went over his benefits with him and told him that I would get a letter out to him explaining everything. He thanked me.

Insured also indicated that he had an angioplasty.

MAM 01-04-01

ACTION PLAN & LOG

Individual Disability Claims

INSURED: Vincenzo Mazzamuto HOME TELEPHONE: 717 243 0353

ADDRESS: 501 Limestone Rd WORK TELEPHONE: /

CITY: Carlisle STATE: PA ZIP: 17013

DOB: 5 / 25 / 55 SSN: 190 / 56 / 5744 DATE OF DISABILITY: 7 / 22 / 00

[X] Sickness or [ ] Accident Received by Claim Rep: / / DATE OF NOTICE: / /

DIAGNOSIS: heart attack, anxiety, back pain

OCCUPATION AT CLAIM: Rest. owner / president

Attorney Representation: Name ____ Tel. /

COVERAGE INFORMATION

CLAIM #	ISSUE DATE	FORM	ELIM PERIOD	MONTHLY BENEFIT	BENEFIT PERIOD	OWN OCC PERIOD	RESIDUAL
H3236167	8-28-93	9132	90	5000	65	yes	yes

Exclusions/Riders/Waivers

[ ] Yes - Guarantee Issue [ ] Yes - FICA Expected RTW / / RTW exceeded 6 Months? [ ] Yes

[ ] Yes - Contestable [ ] Yes - ERISA [X] Yes - Late Notice New Notice Call 1 / 4 / 01

RECOMMENDED ACTION

- [ ] Employer Letter
- [ ] FICA Letter
- [X] Field Referral
- [ ] Reservation of Rights
- [ ] GENEX Referral
- [X] Verify occ.
- [ ] Request occ. desc from EY
- [X] APS
- [X] AP Rec
- [X] Hosp Rec
- [ ] W/C Rec
- [ ] Other Carriers
- [ ] HMO/PPO/Maj Med
- [ ] Third Party Action
- [ ] DEQY
- [ ] SEQY
- [ ] Casualty Index Bureau
- [ ] Data Base Search (super bureau etc)
- [ ] Financial Review
- [ ] Tax Returns/4506
- [ ] Other recommendations (see below)
- [ ] SS Letter
- [ ] License Check
- [ ] Waiver of Premium

Recommendations: get recs: back to 98 write Hx to (I) send to field (unannounced to resteraunt) get ool.

CLAIM REPRESENTATIVE: Melissa Magner DATE: 1/8/01

CONSULTANT: Diane Cahill DATE: 1/8/01

NYLCL00561

ROBIN ANDREWS [redacted]
01/09/2001 09:15 AM

To: Records Operations Chattanooga@Unum
cc: Melissa Magner/Provident Life/US@Unum
Subject: closed NYL File

Good Morning, could you please send me the following closed Individual NYL file on:

Mazzamuto, Vincenzo Clm# 13-h3236167-001 Box# 79270/97-091 Cost Center 8175

Charge out to Melissa Magner 799-26

My route# is 775-52 or W200M, thanks

14
11
5
3

NEW YORK LIFE

DISABILITY INCOME CLAIM INFORMATION

NAME Mongomuto Vincenzo SS# 196-56-5244 D.O.B 5/25/55

POLICY NO. 38361167 CLAIM NO. 214262 POLICY FORM 9132 PA

AGENT(S) NAME & CODE Salvatore Ferrucci G.O. V 44 Conshohocken

X DISABILITY INCOME ___ INCOME INSURANCE ___ BOE

BENEFIT TERM ___ MONTHLY BENEFIT ___ COMMENCEMENT DATE ___

EFFECTIVE DATE 8/28/93 DATE OF PART I ___ DATE OF PART II ___

RIDERS (with Effective Dates if after policy issue) RD

MONEY TAKEN (Yes or No) ___ PARAMEDICAL (Yes or No) ___

OCCUPATION & DUTIES ON APP ___

OCCUPATION & DUTIES AT CLAIM ___

UNDERWRITING OCC CODE ___ NET INCOME ON APP ___ NET INCOME ON IR ___

OTHER INSURANCE (Company, Amount, Policy #, Effective Date, Still In Force?) ___

PRIOR MEDICAL HISTORY ___

SUB-STANDARD: SPECIAL CLASS W/ REASON ___ EXCEPTION RIDER NO. W/ CONDITION Contra. | LOSS INCURRED 4/13/96

NATURE OF THIS INJURY OR SICKNESS Low back Strain Lumbar Strain

NUMBER OF CLAIMS UNDER THIS POLICY ___ MIB CODE: ___

PRIOR CLAIMS AND DIAGNOSES ___ 10/23/94

DISPOSITION & DATE: PAID ___ REOPENED ___ CLOSED W/O PAYMENT ___

21143 6/94

NYLCL00233

NAME Mazzarinti, Vincenzo
N214282.

DATE	CLAIM ACTION	$ TOTAL INSURANCE

DRUM DA

03/20/97 recd profs from kenneth j.stokum advising reveiw of complaints and disciplinary actions revealed no reportable actions against agt ferrigno.
03/20/97 SENT REQUEST TO MANAGING PARTNER OF V44 FOR S/S FROM AGT.

3/24/97 File Action from RSB Noted

3/24/97 Noted fax from GO w/ statements Agt's answers to questions of 3/20/97 memo. Called GO. [illegible] from Agt [illegible] + date the statement

3/25/97 Noted faxed from GO (w/ last) Sign & date awaiting Response from Insd

3/26/97 Recd interim report from RSB Inc, await final Rpt. w/ prescription info from Carlisle [illegible] & CVS pharmacy

04/11/97 AGT'S ORIGINAL S/S, INSD'S REPLY & INTERIM REPORT W/INFO FROM CALISLE PHARMARCY NOTED. REFERRED FILE TO ADAM WEINSTEIN IN OGC.

04/16/97 FILE RETURNED FROM OGC. REFERRED FILE TO AVP MCGRATH TO NOTE OGC'S REPLY OF 4/15/97 WITH RECOMMENDATION THAT WE ACCEPT LIABILITY.
GPH

4/21/97 File returned from AVP McGrath Liability accepted Ben pd [illegible] from [illegible] 10/23/96 [illegible]

539 12-62 Printed in U.S.A

NYLCL00224

NEW YORK LIFE INSURANCE COMPANY
51 MADISON AVENUE
NEW YORK, NY 10010-1603
FERRIGNO,SALVATORE

VINCENZO MAZZAMUTO
501 LIMESTONE RD
CARLISLE, PA
17013-4348

EXPLANATION OF BENEFITS

APRIL 21, 1997

INSURED: VINCENZO MAZZAMUTO
POLICY NUMBER: H3236167
CLAIM NUMBER: N 214282

PAYMENT HAS BEEN APPROVED BY:
GLORIA PHELPS
(212)576-7000

********** FILE COPY **********

THE FOLLOWING CHECK REPRESENTS BENEFITS FROM JUL 02, 1996 THROUGH OCT 23, 1996 UNDER YOUR DISABILITY INCOME POLICY AND APPLICABLE RIDERS.

BASE DISABILITY INCOME	$7,466.67
ADDITIONAL MONTHLY INCOME	$3,733.33
COST OF LIVING FOR ADDITIONAL MTHLY INC	$373.33
COST OF LIVING FOR ADDITIONAL MTHLY INC	$373.33
REFUND OF PREMIUM AMOUNT	$1,502.67
TOTAL PAYMENT	$13,449.33

CONSISTENT WITH THE WAIVER OF PREMIUM BENEFIT INCLUDED IN YOUR POLICY, WE ARE WAIVING/REFUNDING PAYMENT OF PREMIUM(S) BEGINNING WITH THE ONE DUE 08/28/96 AND ENDING WITH THAT DUE 08/28/96. PREMIUMS WERE AGAIN PAYABLE 02/28/97. THE APPLICABLE REFUND AMOUNT OF $1,502.67 IS INCLUDED IN THE ATTACHED CHECK.

PLEASE NOTE THAT CONSISTENT WITH YOUR POLICY, THE PREMIUMS REFUNDED AND/OR WAIVED REPRESENT THOSE FALLING DUE UP TO 3 MONTHS BEYOND THE DATE YOUR CLAIM TERMINATED.

BASED ON THE INFORMATION WE HAVE RECEIVED WHICH INDICATES YOU HAVE MADE A RECOVERY, THE ENCLOSED CHECK REPRESENTS OUR FINAL PAYMENT FOR THIS LOSS.

CLAIMS DIVISION
DISABILITY INCOME DEPARTMENT

NYLCL00217

UNUM

Protecting everything you work for

January 15, 2001

Vincenzo Mazzamuto
501 Limestone Road
Carlisle, PA 17013

Claim # 13-H3236167-002

Dear Mr. Mazzamuto:

Thank you for the courtesies you extended me during our recent telephone conversation. I would like to take this opportunity to explain the status of your claim.

As we discussed, your policy was issued with a 90-day elimination period that must be satisfied before benefits can begin to accrue. Using a disability date of July 22, 2000, benefits would begin to accrue as of October 20, 2000.

Please note that your policy requires that written notice of claim must be given to us within 30-days after a disability starts or a covered loss occurs, or as soon thereafter as reasonably possible. As your written notice was not submitted within this time frame, our evaluation of your claim may be delayed.

Please note that we have requested your medical records from Dr. Douglas Bower and Carlisle Hospital. This information is needed before we can determine our liability on your claim. Your policy states that a claim will be payable when all information that is necessary for us to make a decision is received.

Also, for us to get a better understanding of your occupation, we ask that you please complete the enclosed Occupational Description Form, in full. Please complete this form indicating your specific duties that were performed prior to your disability and the amount of time spent in each duty.

Lastly, so that we may have continuing certification of your disability, we ask that you please complete the enclosed Progress Report, in full, with the help of your attending physician. Please be sure that he/she indicates all dates of recent treatment as well as to certify to your ongoing condition.

Thank you for your anticipated cooperation and if you should have any questions regarding the above, please do not hesitate to contact us.

Sincerely yours,

Melissa Magner, X6710
Claim Representative
The New York Life Insurance Company
UNUMProvident Corporation

Enc: pr, re

B

NEW YORK LIFE INSURANCE COMPANY
NEW YORK LIFE INSURANCE COMPANY AND ANNUITY CORPORATION
(A DELAWARE CORPORATION)
NYLIFE INSURANCE COMPANY OF ARIZONA
(Not licensed in Every State)
PO BOX 6916, CLEVELAND OH 44101, (800) 695-9873
The Company You Keep

August 15, 2002

Vincenzo Mazzamuto
501 Limestone Rd
Carlisle PA 17013

Policy: 44 904 932
Claim: 368 799

Dear Mr.Mazzamuto:

Thank you for sending us the information we requested. I am pleased to advise you that we have re-approved your claim for Waiver of Premium Disability Benefits beyond August 3, 2002.

A check for the refund of the August 2002 Annual premium has been sent under separate cover. All future premiums will be waived while you are totally disabled, as defined in your policy.

Please let us know if you return to work or if your total disability ends. If you have any questions regarding this claim, please let me know.

Sincerely,

Therese A. Sindelar
Ext 8724

cc: Salvatore Ferrigno V44
Richard C Angino

NATIONAL UNDERWRITER
Life & Health/Financial Services Edition

REGULATION

Public Criticism Of COLI Sales Spurs Regulators To Revamp Guidelines

By **Jim Connolly**

Public criticism over the sale of corporate-owned life insurance has regulators reexamining how the product is regulated.

As a starting point, a 10-year old guideline (*Model 602 of NAIC model laws*) developed by the National Association of Insurance Commissioners, Kansas City, Mo., will be reexamined and possibly revamped.

However, regulators who are part of the NAIC's COLI working group, have left open the possibility of developing a whole new model law that states can adopt to enforce how the product is sold and disclosed.

The working group's chairman, North Dakota Commissioner Jim Poolman, says the issue of affirmative consent, or an employee giving the employer the OK to purchase COLI on the employee's life, should be a top priority.

According to the NAIC, fewer than half of the states require the affirmative consent of an employee. Fifteen states do require it and five states have an opt-out provision in which an employee must say it is not all right for a company to purchase COLI in order to prevent the firm from buying a life insurance contract on his life.

Other findings, according to the NAIC, are that most states require an insurable interest at the time coverage becomes effective; and laws in half of the states allow coverage to be maintained on non-management and retired employees.

> Regulators say employee consent is important to COLI sales

The issue of affirmative consent being required for a Voluntary Employees' Beneficiary Association Trust contract which is being used as an irrevocable component of a 501c3 trust was raised by the industry, but regulators responded that even with the issue of irrevocability, at the very least, some sort of notification would seem appropriate.

Notice and consent should be part of the process, which is a stand that the National Association of Insurance and Financial Advisors has taken, according to Bill Anderson, vice president and associate general counsel with NAIFA, Falls Church, Va.

The "surprise factor" that occurs when a spouse finds out that a policy has been taken out on a deceased husband or wife, underscores the need for notification and consent, says John Pouliot, a regulator with the Ohio insurance department. NU

LITIGATION

Doctor's Suit Asserts UnumProvident Had Policy Of Denying Claims

By **Marcella De Simone**

UnumProvident Corp. is accused in a lawsuit of denying disability claims whether they were valid or not.

The suit, filed June 28, was brought by Patrick Fergal McSharry, a doctor who once worked as a medical director for UnumProvident in Chattanooga, Tenn. He claims the company employed doctors "to provide language and conclusions supporting denial of claims."

The suit also claims that when he began writing his reports "accurately and without the foregone conclusion to deny the claim...(McSharry) began to suffer retaliation," including "verbal and written write-ups and warnings. He was subjected to constant criticism and ostracism."

The suit, which claims McSharry spoke with other medical personnel about "the illegality of (Unum's) practices," says McSharry was fired in January for "disruptive behavior."

Tom White, UnumProvident vice president, corporate relations, says the company "will definitely fight (the lawsuit); our company embraces very high ethical and professional standards, we deny all allegations against wrongdoing and will rigorously defend ourselves."

He says McSharry had been hired in 1999 as a consultant and worked as a medical director from Nov. 1, 2000 to Jan. 8, 2002 when he was fired "for performance."

"I think it's important to note that at no time did his duties include making determination to benefits," White says. "His duty was to review medical records and answer questions about medical records, but not to decide whether a claim was valid."

McSharry is seeking back wages, reinstatement to his former position, compensation for mental suffering, humiliation and embarrassment, punitive damages and costs of attorney fees.

McSharry's lawyer Anita Hardeman of Burnette, Dobson & Hardeman, Chattanooga, Tenn., did not respond to requests for comment. Her assistant says UnumProvident has 30 days from the time the lawsuit was filed to respond. It has not yet done so. NU

Introduction to the Claims Manual

This is the first Claims Manual created for UnumProvident Corporation's Customer Care Center. It is designed and intended to be a reference guide to claims professionals and others in the Customer Care Center on the handling of claims under the contracts that UnumProvident sells and administers. In effectuating that intent, the following key points apply to this Claims Manual:

1) Every claim submitted to UnumProvident is different and must be decided on its own unique and individual facts. Accordingly, this manual generally contains guidelines, rather than definitive, "hard and fast" rules on the handling, evaluation and determination of claims. These guidelines do not offer a prescribed answer to each claim situation. Rather, such answers must be arrived at based on the specific and particular facts of the claim, as noted above. This claims manual is not meant to replace independent thought and analysis by the Customer Care Representative. Depending on the unique facts of a claim, one or more of the guidelines contained in this Manual may or may not be applicable.

2) In the handling of each claim, the Customer Care Center will strive to comply with all applicable laws. In support of that goal, this Manual contains overviews of a variety of legal rules and guidelines that may apply to specific claims. The absence of any other applicable requirements from the Manual does not signify in any way noncompliance with such laws. In the event of any inadvertent conflict between any guidelines in this Manual and applicable law, the applicable law shall govern the situation.

3) In this first Manual, UnumProvident does not intend to cover every single claim practice and procedural topic. Rather, this Manual is and shall be a dynamic, interactive document to which procedural and practice guidelines on additional topics will be added over time, as appropriate.

4) This Manual will not include, at this point, guidelines with regard to the Colonial Life & Accident claims operation.

5) Once created, this Manual will be distributed to all Customer Care Centers and claim operations, as will additions and updates.

States: Pennsylvania

Non-ERISA Claims

Unfair Claims Settlement Practices Act and Other Claims Handling Laws: Pa.Adm.Code 146.1 et seq.; Pa.St.Ann. 1171.5(10).

1. Adopted law similar to NAIC Model; for general provisions see NAIC Model Act and Regulations.
2. Specific Time Restrictions:
   Acknowledge receipt of notification of claim: 10 days
   Provide necessary claim forms: 10 days
   Respond to communications from claimant: 10 days
   Begin investigation of claim: None
   To complete investigation of claim: 30 days
   Notify claimant that more time is needed to review claim: 15 days after receipt of proofs of loss
   Send follow-up letters that investigation is incomplete: 30 days from the date of the initial notification requesting more time, and then 45 days thereafter.
   Accept or deny claim after receipt of proofs of loss: 15 days
   Pay claimant after acceptance of liability: None
   Pay after settlement of claim: None
   Respond to inquiry from Department of Insurance: 15 days

ERISA & Non-ERISA Claims

A. Pennsylvania does not tax sick pay.
B. Late Notice/Prejudice Rule: Insurer needs to demonstrate prejudice before a claim can be denied due to late filing. Perry v. Middle Atlantic Lumberman's Mutual, 542 A.2d 81 (Pa.1988); Brakeman v. Potomac Ins. Co., 371 A.2d 193 (Pa.1977); Weiner v. Metropolitan Life Ins. Co., 416 F.Supp.551 (E.D.Pa. 1976).

ERISA Claims

Located in the 3rd Circuit Federal Court of Appeals.

Guidelines for Evaluating an Occupation

Most UnumProvident policies condition eligibilty for benefits (at least for some period of time) on an individual's inability to perform some or all of the material and substantial duties of his "own occupation" due to sickness or injury. For some claimants, the degree of medical impairment is so severe that eligibility for benefits can be determined without an extensive analysis of the occupation. In other situations, an analysis of the claimants' pre-disability occupation is needed to evaluate their eligibility for benefits.

Questions may arise in interpreting "occupation" as defined in the policy. Some policies define 'occupation' in more detail than others. The following guidelines have been developed for identifying and evaluating the appropriate "occupation" for a claimant.

This guideline applies to all contracts that refer to the inability to perform one's own or regular occupation. If the contract includes a specialty definition or inability to perform a particular job with the employer, please keep that in mind during the evaluation. We may want to consider review of the Underwriting file for additional occupation information.

In determining the insured's occupation, we must develop a thorough understanding of the work the claimant was performing immediately prior to disability.

Establishing Occupation
In determining what an insured's own occupation should be, consider the following:

- What were the material and substantial duties the claimant performed?
- How did the insured spend his time?
- From what activities was his income generated?

The insured's "own occupation" or "regular occupation" is the occupation which the insured was engaged in at the time of the disabling injury or sickness.

The following sources can be used to establish the insured's occupation:

- appointment books, calendars, schedules (including surgical schedules), or other evidence of how the insured spent his time prior to disability;
- billings;
- job description, personnel file, etc., if the insured is an employee of a firm that generates such materials;
- evidence of earned income W-2s, tax returns, etc.;
- authored works such as reports, memoranda, publications, etc.;
- timesheets; and
- vocational resources such as Dictionary of Occupational Titles, Occupational Outlook Handbook etc.

Occupation must be determined using fair and reasonable standards of review. If an occupation, broadly defined, includes a particular procedure, but the insured has not performed such procedures in the past to a material and substantial degree, the inability to perform that procedure should not result in a finding of disability.

Occupation does not include the particular physical environment in which the insured was performing his occupational duties prior to disability. For example, if an insured was a bookkeeper in an old building that, because of its unique structure, contained only a narrow flight of stairs that the insured cannot now climb, this does not render him unable to perform his occupational duties as a bookkeeper.

Certain state or federal courts have interpreted the term "occupation" in prior disabiliy cases. Each such holding is based on the unique facts of the case. Florida, however appears to have adopted a more narrow definition of "own occupation." Refer to the Legal Department if you have questions regarding the law of any state regarding "occupation."

Job vs. Occupation Assessment
The essence of the job vs. occupation or own occupation assessment is a comparison of the specific duties performed prior to disability with the occupational duties as generally performed in the national economy.

The term "occupation" is often interpreted to be the same as a "job." This interpretation is incorrect as a job differs from an occupation in that a job is a set of specific duties performed at a particular employer whereas an occupation is a broader description of the type of work as is generally performed in the national economy.

Vocational resources are available to assist in determining a claimant's occupational duties as generally performed in the national economy.

Analyzing Nurse Occupations
The Nursing profession has changed considerably over the years resulting in a variety of RN positions. When evaluating a claim involving a registered nurse, the restrictions and limitations may impact the claimant's ability to perform some if not all jobs within the Registered Nurse Occupation.

We do not offer a specialty definition of disability for nurse positions. However, we do recognize there are classes of nursing positions that require separate and distinct training and license to perform. Therefore the following positions are recognized as specialty occupations when administering claims:

- Nurse Anesthetist (CRNA)
- Nurse Midwife
- Nurse Practitioner

RN and LPN/LVN positions should be considered on a general basis vs. specific position with a particular employer. If we determine that an RN/LPN/LVN is reasonably capable of performing the occupation in another situation, the person is not disabled. In making this determination, careful review of the job demands as well as prior education, training (credentials, certifications, etc.) number of years in specific RN jobs and types of work experience is needed. Prior to referral to the Vocational Rehabilitation Consultant, we should obtain the Nurse Training, Education and Experience form.

Labor Market Information/Geographical Proximity
During the management of a claim it may be necessary to obtain labor market information. The most frequent need for labor market information is for a Labor Market Survey (LMS) during an any occupation evaluation at change of definition to determine the existence and wages of alternate occupations.

Labor market information is a tool that can:

- provide wage information
- provide information about existence of occupations
- identify how an occupation is performed
- identify existence of occupations in local or national labor markets

Labor Market Surveys (LMS) are used when calls to employers are needed to obtain information regarding wages and/or existence of occupations within a given labor market. Calls to employers

Ongoing Claimant Certification of Disability

Background

During the active management of a claim we frequently ask for information supporting ongoing payment and calculation of benefits. One tool used to obtain data is the supplemental claim statement. This form requests information from the claimant and the attending physician.

To ensure that we are requesting the appropriate information at the right time and to establish a consistent approach to claims management, we should adhere to the following guidelines.

Applicability

Group LDU, IDI, Life
This does not apply to SDU claims due to limited duration.

Attending Physician Statement

We should request updated medical information as needed to support continued payment of a claim. This information can be obtained through various sources including office notes, attending physician statements, Independent Medical Examinations, etc.

When we are actively managing an LTD claim, we should be requesting a completed Attending Physician Statement at least quarterly. Some impairments may warrant more frequent attending physician statements. Actively managed IDI claims will usually require monthly attending physician statements.

Claimant Statement

When we are actively evaluating a claim, the fully completed claimant statement must be requested minimally on a quarterly basis. For IDI claims, we should consider monthly statements given the lack of a separate employer/employee relationship to assist with verification of information. While we may be using various tools to obtain updated medical data, we need to regularly get updated statements from the claimant.

Rationale

The claimant statement provides ongoing documentation, which will help direct the claim investigation. The claimant is submitting a written document that provides:

- written statement of the claimants activities (including any part-time work)
- updated authorization to release information
- current physical address and telephone number
- other insurance/income status

When we are determining what information is needed, the updated statement will help set our future investigative direction.

Extended Duration Unit

Extended Duration Unit (EDU) will obtain an updated claimant statement for claims every 12-36 months based on the criteria established by the EDU.

Conclusion

The claimant statement is an important tool that will assist in the ongoing management of a claim. The frequency guideline will help ensure that we are getting the updated information necessary to manage a claim.

Reminder: Each claim is unique and should be evaluated on its own merits.

Medical Information

All information obtained during the claim evaluation process must be considered when making decisions regarding liability. Key components of the evaluation process include but are not limited to consideration of:

- Contractual Provisions
- Claimant Activities
- Occupational Duties
- Financial Information
- Medical Information

As illness or injury is at the foundation of every claim, medical information is fundamental to an understanding of a claimant's restrictions and limitations, opportunity for recovery, and capacity for return to work.

The analysis of medical information drives the success of early intervention and medical case management where we partner with treatment providers to facilitate rehabilitation and return to work in appropriate cases.

During the claims evaluation process, medical information should be assessed for its credibility and relevance. There are a number of avenues, beyond the treating healthcare provider, available for obtaining an assessment of the medical information and/or the claimant's restrictions and limitations including:

- Independent Medical Examination (IME)
- Functional Capacity Evaluation (FCE)
- Internal Medical Personnel

Independent Medical Examination (IME) and Functional Capacity Evaluation (FCE)

An IME and/or FCE is an examination of the claimant by an external healthcare provider performed at the request of the Company.

The IME and/or FCE are reserved as a claim management tool and will only be appropriate in certain situations. As each claim is unique, the specific facts of the claim will determine whether an IME and/or FCE is an appropriate step. If an IME and/or FCE is completed, it is generally appropriate to provide the treating healthcare provider with a copy of the report while proceeding with claims management activities.

Appropriate internal medical resources should be involved in the discussion of claims being considered for denial based on medical grounds.

Customer Care Center Medical Department

Internal healthcare expertise is available to assist with the analysis of medical information. Our physicians, nurses and other allied healthcare professionals are available to:

- Assess medical information from the perspectives of adequacy, consistency and credibility
- Apply current medical knowledge to data regarding diagnosis, treatment, prognosis, and impairment;
- Offer advice regarding obtaining future medical information;
- Attempt to clarify a situation with a peer-to-peer call; and
- Evaluate restrictions and limitations and their expected impact on work capacity.

Internal medical resources are expected to apply an appropriate level of critical scientific

analysis to the review of medical information; their analysis will be guided in part by the following principles:

- Office notes, test results or other medical records which record findings of the patient's visits are generally more useful than a 'narrative summary' from the attending physician.
- More recent medical information is often more informative regarding current status than older data.
- An opinion from a healthcare provider with a higher level of expertise, specialization or training is generally more credible or persuasive than the opinion from a provider with a lesser level of expertise, specialization, or training.
- A medical opinion based on scientific evidence is frequently more compelling than a medical opinion without such a foundation.
- A medical conclusion/opinion founded on detailed specific facts or observations is generally more persuasive than a medical conclusion without such a foundation.
- When an attending healthcare provider is recommending restrictions and limitations, we need to consider the basis behind the recommendation and determine whether we have the same information/reports the attending healthcare provider used in making their determination.

From the perspective of the claims adjudication professional:

- A generic statement from an attending healthcare provider supporting disability, in most cases, is not sufficient to continue benefit payments. A factual basis behind the opinion should be evident. It may be relevant to evaluate whether the attending healthcare provider considered the claimant's work capacity relative to their occupation setting.
- The claim file should reflect the rationale used to reach conclusions when evaluating differing medical opinions.

Conclusion

Medical information is an important component of the claims investigation process. Our medical resources can provide assistance with the evaluation of the information including diagnosis, chart records/diagnostic test results, treatment protocols and prognosis.

File Documentation

Insurers are required by law to establish, maintain, and retain claim files. File documentation should be fact-based and professionally worded. All communications bearing on the claim should be documented and included in the file, including telephone conversation notes, e-mails, etc. All documents pertinent to the claim should be included in the claim file. All documents should be added in chronological order based on the date they were generated or the date of their receipt, whichever is later. All documents generated by UnumProvident should be legible, and include a date and the name or initials of the author. All documents should be complete.

UnumProvident employees handling claims should not maintain any files concerning a claim other than the claim file itself.

Attorney-client communications contained in the claim file should be designated "Attorney-Client Communication/Privileged and Confidential."

Material should not be removed from a claim file unless it was included by mistake; e.g., documents not related to the claim.

E

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

SYRACUSE EXPLORATION COMPANY, :
Plaintiff
:
vs. : CIVIL ACTION NO. 1:CV-97-1405
:
NORTHBROOK PROPERTY & :
CASUALTY INSURANCE COMPANY,
Defendant :

M E M O R A N D U M

I. Introduction

Plaintiff, Syracuse Exploration Company ("Syracuse"), has filed a motion for new trial. This was a bad faith claim in which the jury exonerated Defendant's ("Northbrook") handling of Plaintiff's insurance claim. See 42 Pa. Cons. Stat. Ann. § 8371 (West 1998). Plaintiff alleges that the court made errors in ruling on motions in limine, admitting or excluding evidence at trial, and in instructing the jury. As discussed below, we conclude that these claims of error do not warrant the relief sought.

In addition, Defendant has filed a motion to strike certain post-trial affidavits submitted by the Plaintiff concerning several occurrences during the trial. We well deny that motion because those filings are authorized by Fed. R. Civ. P. 59.

II. Background

Syracuse was insured by Northbrook for damage to its construction equipment. On September 16, 1997, Syracuse commenced this action claiming that Northbrook acted in bad faith in handling a claim involving damage to a drill rig. Syracuse alleged that Northbrook unreasonably delayed paying its claim for damage to the rig; canceled the policy following submission of the claim; took an improper deduction for depreciation; and that the handling of the claim caused Syracuse to sustain lost profits. The only question at trial was whether Syracuse proved by clear and convincing evidence that Northbrook's handling of Syracuse's claim was done in bad faith. The jury returned a verdict in favor of the Defendant on June 9, 1999.

III. Standard of Review

A motion for a new trial under Fed. R. Civ. P. 59 may be granted "if required to prevent injustice or to correct a verdict that was against the weight of the evidence." American Bearing Co., Inc. v. Litton Indus., 729 F.2d 943, 948 (3d Cir. 1984); Alexander v. Morning Pride Mfg., Inc., 913 F. Supp. 362, 372 (E.D. Pa. 1995). A new trial may be necessary where the verdict is so contrary to the weight of the evidence that it represents "a miscarriage of justice" or "cries out to be overturned or shocks our conscience." Williamson v. Consolidated Rail Corp., 926 F.2d 1344, 1353 (3d Cir. 1991); Delli Santi v. CNA Ins. Co., 88 F.3d

192, 201 (3d Cir. 1996). "Injustice" requiring a new trial may include the improper exclusion of evidence, or a jury instruction that misstates the law, so long as the error "appears to the court inconsistent with substantial justice." Fed. R. Civ. P. 61; Bailey v. Atlas Powder Co., 602 F.2d 585, 588 (3d Cir. 1979).

IV. Discussion

A. *Evidentiary Rulings Before Trial*

Prior to trial Defendant submitted several motions in limine, all of which were granted. Two of these motions stemmed from a partial summary judgment that was granted to the Defendant. The court determined that Plaintiff had failed to produce evidence, first, that the depreciation calculation used by Defendant was unreasonable or was reached in bad faith and, second, that Plaintiff had sustained lost profits due to Defendant's handling of its claim. Accordingly, we granted Defendant's motion in limine to exclude evidence as to lost profits or the method it used to determine depreciation.

Plaintiff argues that the jury should have been permitted to consider evidence of lost profits and Defendant's handling of the depreciation item. However, because Plaintiff failed to produce evidence, in response to Defendant's summary judgment motion of any losses it sustained, or that Defendant's calculation of depreciation was done in bad faith, Plaintiff

forfeited these claims. Inasmuch as these allegations could no longer serve as a basis for Plaintiff's bad faith claim, we find no error in excluding this evidence at trial.

In response to a third motion in limine by Defendant, we excluded evidence of Defendant's decision not to renew Plaintiff's insurance policy based on Plaintiff's loss history. Renewal of the policy was not relevant to the issue of the Defendant's handling of Plaintiff's claim. Plaintiff now argues that the non-renewal was itself evidence of bad faith.

Plaintiff's argument is not supported by decisions interpreting the Pennsylvania bad faith statute. See Perschau v. USF Ins. Co., 1999 WL 162969, at *4 n.6 (E.D. Pa. Mar. 22, 1999) (sending notice of non-renewal to insured not evidence of bad faith); Belmont Holdings Corp. v. Unicare Life & Health Ins. Co., 1999 WL 124389, at *3 (E.D. Pa. Feb. 5, 1999) (holding that bad faith statute applies to handling of insurance claims and not to contract disputes, including threats not to renew policy); Kurtz v. American Motorists Ins. Co., 1997 WL 117008, at *2-3 (E.D. Pa. Mar. 12, 1997) (reviewing case law and holding that bad faith statute does not apply to non-renewal of automobile policy); see also U.S. Metal & Coin Jewelry, Inc. v. Jewelers Mut. Ins. Co., 1996 WL 494149 (E.D. Pa. Aug. 26, 1996) (allowing claim of bad faith based on the non-renewal of a policy, but finding none where decision was legitimately based on insured's loss history). The cases cited by Plaintiff are not persuasive because they do not

relate to the Pennsylvania bad faith statute or to non-renewal of insurance based on loss history. Accordingly, we conclude there was no error, and certainly no prejudice, in excluding this evidence.

A final pre-trial ruling challenged by the Plaintiff is our order of December 31, 1998, sanctioning Plaintiff for submitting an expert report three and one-half months after the deadline for submitting such reports. We ordered that the expert's report be stricken from the record. Plaintiff correctly points out that before imposing the sanction of striking proposed testimony by a witness we must consider:

> (1) the prejudice or surprise in fact of the party against whom the excluded witnesses would have testified,
> (2) the ability of that party to cure the prejudice,
> (3) the extent to which waiver of the rule against calling unlisted witnesses would disrupt the orderly and efficient trial of the case or of other cases in the court, and
> (4) bad faith or willfulness in failing to comply with the court's order.

Meyers v. Pennypack Woods Home Ownership Assn., 559 F.2d 894, 904-05 (3d Cir. 1977), overruled on other grounds, Goodman v. Lukens Steel, 777 F.2d 113 (3d Cir. 1985), aff'd, 482 U.S. 656, 107 S. Ct. 2617, 96 L. Ed. 2d 572 (1987); see also Elf Atochem N. Am., Inc. v. United States, 882 F. Supp. 1497, 1498 (E.D. Pa. 1995). Although we did not require Defendant to establish that admitting the expert's proposed testimony would cause prejudice, nor whether such prejudice could be cured, we did determine that

Plaintiff's behavior was in disregard of the rules of civil procedure and the case management plan for this case. Furthermore, although Plaintiff characterized the expert as a "rebuttal expert," his report contained an analysis of Defendant's handling of Plaintiff's insurance claim. There was no excuse for Plaintiff awaiting the report by Defendant's expert before presenting its own witness. To allow the Plaintiff to introduce opinion evidence which could have (and should have) been produced initially would have affected the orderly prosecution of the case. Following the Plaintiff's disregard of the discovery deadline (through a request for production of documents), we conclude that the sanction imposed was a valid exercise of our authority under Fed. R. Civ. P. 37.

B. *Evidentiary Rulings During Trial*

When the president of Syracuse began to testify about the company's debts we sustained Defendant's objection that this testimony was not relevant to the bad faith issue. In arguing that this testimony was admissible to establish bad faith, Plaintiff cites two cases where the insurer's knowledge of its insured's difficult financial condition may have been a factor in proving bad faith. See Polselli v. Nationwide Mut. Fire Ins. Co., 1995 WL 430571 (E.D. Pa. July 20, 1995) (holding that insurer acted in bad faith in delaying payment of living expenses when insurer knew that insured had no place to live after fire

destroyed home); South Park Aggregates v. Northwestern Nat'l Ins. Co. of Milwaukee, 847 P.2d 218, 225 (Colo. App. 1992) (holding that insurer's awareness of financial consequences to insured in denying claim was evidence of bad faith). However, Plaintiff never offered to show that Defendant knew of the Plaintiff's financial status. Because an insured's financial condition, standing alone, cannot establish bad faith on the part of the insurer, there was no error in excluding this evidence.

Plaintiff contends that admitting testimony by the Defendant's expert, a lawyer who handles insurance claims, was error because the testimony included an opinion concerning the question for the jury, i.e., whether Defendant acted in bad faith. We find no error. First, Federal Rule of Evidence 704 permits testimony as to the ultimate issue. Second, the expert testified primarily about the facts of the case and whether particular actions were acceptable practice within the insurance industry. Defendant's expert did not testify regarding decisions or interpretations of the law as did the attorney expert in Nieves-Villanueva v. Soto-Rivera, 133 F.3d 92 (1st Cir. 1997), on which the Plaintiff relies. On those few occasions where the expert's testimony appeared to veer in the direction of offering a legal opinion, the court sustained Plaintiff's objections. For example, the expert was not permitted to testify as to the difference between bad faith and a mistake. (Tr. at 412.) Accordingly, we believe the expert's testimony was properly admitted.

During trial, Defendant called as a witness an independent appraiser, Charles Stanford, who adjusted the claim on its behalf. Stanford testified from memory about his handling of the Plaintiff's claim, and on cross-examination Plaintiff's counsel asked to see Stanford's files. Stanford stated that he did not have them because counsel for the Defendant told him it was not necessary to bring them to court. (See Stanford Aff. ¶ 5; Zelle Aff. ¶ 8.)[1] Plaintiff contends that defense counsel violated Rule 3.4 of the Rules of Professional Conduct[2] and that this behavior is grounds for granting a new trial.

This argument lacks merit. In its initial disclosures in December 1997, the Defendant informed Plaintiff that Stanford was involved in handling the Plaintiff's claim. (Zelle Aff. ¶ 3.) Defendant also indicated in its pre-trial memorandum that Stanford would testify at trial. Because Stanford is not an employee of

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[1] The court allowed Defendant additional time to submit affidavits in response to Plaintiff's arguments concerning Stanford's testimony. Plaintiff argues that we lacked the authority to grant an extension. Contrary to Plaintiff's position, the court did have discretion under Fed. R. Civ. P. 6(b) to extend Defendant's time for filing affidavits under Fed. R. Civ. P. 59(c). Although Rule 6(b) lists specific rules for which the time periods may not be extended, Rule 59(c) does not appear in this list.

[2] Rule 3.4(a) provides that "[a] lawyer shall not:
(a) unlawfully obstruct another party's access to evidence or unlawfully alter, destroy or conceal a document or other material having potential evidentiary value or assist another person to do any such act.
Pennsylvania Rules of Professional Conduct Rule 3.4(a).

the Defendant, his files were not in the possession or control of Defendant and they were not produced in response to a request for documents. See Fed. R. Civ. P. 34. However, Plaintiff had ample opportunity to subpoena Stanford's files. The failure to do so cannot be blamed on the Defendant nor provide a basis for a new trial. See Buchholz v. Rockwell Int'l Corp., 120 F.3d 146 (8th Cir. 1997) (denying motion for new trial for failure to produce documents where opposing party was aware of their existence one year before trial). Furthermore, Plaintiff has not shown that the failure to produce Stanford's files was prejudicial.

C. *Jury Charge*

Plaintiff maintains that a new trial should be granted because the court did not hold a charge conference and because certain instructions he proposed were not given to the jury. A jury charge conference is not required by the federal rules of civil procedure. See Fed. R. Civ. P. 51. Furthermore, a new trial will not be granted due to an incorrect jury instruction, "unless the moving party brought the erroneous instruction to the court's attention at trial." Younis Bros. & Co. v. CIGNA Worldwide Ins. Co., 899 F.Supp. 1385, 1398 (E.D. Pa. 1995), aff'd, 91 F.3d 13 (3d Cir. 1996) (citing Fed. R. Civ. P. 51). This can be accomplished either by seeking a ruling on the proposed instruction or by objecting after the jury is charged. Smith v. Borough of Wilkinsburg, 147 F.3d 272, 275-77 (3d Cir. 1998). In

either case, the party must clearly state what portion of the charge is objected to and why it is objectionable. Id at 277; Fed. R. Civ. P. 51. Despite being provided with an opportunity to object, Plaintiff did not do so, and thus failed to preserve this issue as a basis for obtaining a new trial.

Although we need not consider Plaintiff's arguments regarding the jury instructions, we will nonetheless explain our decision not to include Plaintiff's proposed charges concerning the Unfair Insurance Practices Act ("UIPA"). See Pa. Stat. Ann. tit. 40, §§ 1171.1-.15 (West 1997 & Supp. 1999). Plaintiff's proposed Points for Charge Numbers 5 and 6 listed specific provisions of the UIPA and the companion regulations. Plaintiff's suggested charge would allow a jury to conclude that committing any act prohibited by the UIPA establishes bad faith on the part of the insurer. We do recognize that establishing that an insurer committed acts mentioned in the UIPA may provide support for a bad faith claim. See Romano v. Nationwide Ins. Co., 435 Pa. Super. 545, 554, 646 A.2d 1228, 1233 (1994). Indeed, Plaintiff did introduce evidence that Defendant may not have complied with certain regulations, for example, in the timeliness of its response to Plaintiff's initial claim. We believe, however, that instructing a jury on these regulations is inappropriate. The UIPA is concerned with improper conduct that occurs so frequently as to rise to the level of a "business practice." Pa. Stat. Ann.

tit. 40, § 1171.5. The bad faith statute, on the other hand, is concerned only with an insurer's actions in a specific case. See Hyde Athletic Indus. v. Continental Cas. Co., 969 F. Supp. 289, 307 (E.D. Pa. 1997) (observing that "[w]hat constitutes a reasonable set of business practices for the investigation and evaluation of claims is a question properly left to the Pennsylvania Insurance Commissioner, not a judge or a jury"). Instructing the jury on the UIPA might lead to confusion. We believe the better approach is to permit the introduction of evidence showing non-compliance with the UIPA, as the Plaintiff did here, but to allow the jury to decide whether this is evidence of bad faith as that term is defined in the law.

Plaintiff's remaining two grounds center on questions asked by the jury during the course of deliberations. We responded to those questions as we thought appropriate. The Plaintiff did not note any objections to the statements made to the jury and thus failed to preserve these matters for review.

We will issue an appropriate order denying Plaintiff's motion for a new trial.

William W. Caldwell
United States District Judge

Date: September 28, 1999

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

SYRACUSE EXPLORATION COMPANY, :
Plaintiff
:
vs. : CIVIL ACTION NO. 1:CV-97-1405
NORTHBROOK PROPERTY & :
CASUALTY INSURANCE COMPANY, :
Defendant :

O R D E R

AND NOW, this 28th day of September, 1999, upon consideration of Plaintiff's motion for a new trial, filed June 11, 1999 (Doc. No. 113), and Defendant's motion to strike post-trial affidavits, filed June 22, 1999 (Doc. No. 117), it is Ordered that the motions are denied.

William W. Caldwell
United States District Judge

UNREPORTED – NOT PRECEDENTIAL

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 99-3811

SYRACUSE EXPLORATION COMPANY,
Appellant

v.

NORTHBROOK PROPERTY & CASUALTY
INSURANCE COMPANY

Appeal from the United States District Court
for the Middle District of Pennsylvania
(D.C. Civ. No. 97-cv-01405)
District Judge: Honorable William W. Caldwell

Submitted Under Third Circuit LAR 34.1(a)
May 23, 2000
Before: SLOVITER and MANSMANN, Circuit Judges
and WARD, District Judge.

(Filed: May 26, 2000)

MEMORANDUM OPINION OF THE COURT

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*Honorable Robert J. Ward, of the United States District Court for the Southern District of New York, sitting by designation.

MANSMANN, Circuit Judge.

Syracuse Exploration Corporation, the plaintiff in a diversity action alleging bad faith on the part of its insurers under 42 Pa. Cons. Stat. Ann. § 8371, appeals from an order of the District Court granting partial summary judgment in favor of the insurer, Northbrook Property & Casualty Insurance Corporation. Syracuse also appeals from an order of the District Court denying Syracuse's motion for a new trial. Syracuse raises multiple allegations of error with respect to the grant of partial summary judgment, contending that the District Court erred in: (1) concluding that Syracuse failed to produce evidence in support of its bad faith claim based on Northbrook's depreciation and lost profits calculations; and (2) striking the report of Syracuse's expert as untimely. Syracuse raises additional allegations of error with respect to the District Court's denial of its motion for a new trial. Specifically, Syracuse contends that the District Court erred in: (1) precluding the introduction of evidence relating to Northbrook's failure to renew the insurance policy held by Syracuse; (2) permitting Northbrook's expert to express a legal opinion; (3) ruling that Syracuse's owner could not be questioned regarding the financial status of the company; (4) failing to hold a pre-charge conference and to deliver certain instructions requested by Syracuse; (5) formulating inadequate responses to questions posed by the jury during the course of deliberation; and (6) tolerating alleged misconduct on the part of counsel for Northbrook. We are convinced that each of the allegations of error lacks merit and will affirm the orders of the District Court.

I.

The parties are well familiar with the facts underlying this appeal and have referred to those facts in detail in the course of setting forth their respective positions. As a result, we refer to the facts only to provide context for our conclusions of law.

In September 1997 Syracuse filed a diversity action in the Middle District of Pennsylvania, alleging that Northbrook acted in bad faith in violation of Pennsylvania law when it processed an insurance claim for fire damage to a drilling rig owned by Syracuse. Syracuse sought lost profits, compensatory and punitive damages, and attorney's fees.

In January 1998 Northbrook filed a motion for partial summary judgment with respect to that portion of Syracuse's claim based on the deduction of depreciation from the amount owed. This motion was denied, as was Northbrook's motion for reconsideration.

At the close of discovery in August 1998, Northbrook filed a second motion for partial summary judgment on the depreciation and lost profits elements of Syracuse's bad faith claim. Following oral argument, the Magistrate Judge concluded that Syracuse failed to meet its burden of "point[ing] to some evidence of an unreasonable calculation of depreciation and of lost profits." Syracuse Exploration Corp. v. Northbrook Property & Casualty Ins. Co., Civ. No. 1:CV-97-14-5, report and recommendation at 5 (M.D. Pa. October 22, 1998). Accordingly, the Magistrate Judge recommended that Northbrook's

motion for partial summary judgment be granted. In an order dated December 31, 1998, the District Court adopted the report and recommendation of the Magistrate Judge, granting partial summary judgment in favor of Northbrook. In the same order the District Court granted Northbrook's motion to strike a report prepared by Syracuse's expert witness, finding that the report was untimely.

In May 1999 Northbrook filed motions in limine seeking to exclude at trial evidence relating to Syracuse's alleged lost profits and financial status, Northbrook's failure to renew its insurance contract with Syracuse, and the method used by Northbrook to calculate depreciation. In an order dated June 3, 1999, these motions were granted. Trial began on June 7, 1999, and concluded on June 8th with a jury verdict in favor of Northbrook.

On June 11, 1999, Syracuse filed a motion for a new trial alleging that the District Court erred in admitting and excluding certain items of evidence at trial, instructing the jury, and tolerating prejudicial misconduct on the part of Northbrook's counsel. The motion was denied on September 28, 1999. A timely appeal followed. We have jurisdiction pursuant to 28 U.S.C. § 1291.

II.

We address first Syracuse's appeal from the District Court order granting partial summary judgment in favor of Northbrook. Syracuse challenges first those

portions of the order directing that judgment be entered in favor of Northbrook on Syracuse's claim that Northbrook exhibited bad faith in calculating a depreciation deduction and on the claim for lost profits.[1]

A.

The deduction for depreciation and calculation of lost profits.

Pennsylvania law provides a statutory remedy for insurers' bad faith conduct. 42 Pa. Cons. Stat. Ann. § 8371 reads:

> In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, a court may take all of the following actions:
> (1) Award interest on the amount of the claim from the date the claim was made by the insured, in an amount equal to the prime rate of interest plus 3%.
> (2) Award punitive damages against the insurer.
> (3) Assess court costs and attorney's fees against the insurer.

Although the statute does not define the term "bad faith," we have found that: "in the insurance context the term . . . has acquired a peculiar and universally acknowledged meaning." Polselli v. Nationwide Mutual First Insurance Co., 23 F.3d 747, 751 (3d Cri. 1994). "'Bad faith'" on [the] part of [an] insurer is any frivolous or

[1]In a parallel argument, Syracuse contends that the District Court erred in granting Northbrook's motions in limine precluding the introduction at trial of evidence relating to the method by which depreciation and lost profits were calculated. Our finding that the District Court did not err in granting summary judgment with respect to these claims is dispositive of Syracuse's challenge to the District Court's grant of the motions in limine.

unfounded refusal to pay proceeds of a policy . . . . [S]uch conduct imports a dishonest purpose and means a breach of a known duty . . . through some motive of self-interest or ill-will; mere negligence or bad judgment is not bad faith." Id. Based on this definition, we concluded that reckless behavior may constitute bad faith and clarified that a plaintiff bears the burden of proving bad faith by clear and convincing evidence. Id. at 750, 751.

In granting Northbrook's motion for partial summary judgment, the District Court adopted the report and recommendation of the Magistrate Judge in which the Magistrate Judge found, on the two relevant elements of its bad faith claim, that Syracuse failed to meet its burden of proof:

> Syracuse, who has the burden of proof, must point to some evidence of an unreasonable calculation of depreciation and of lost profits to avoid an entry of summary judgment in favor of defendant Northbrook as to these portions of [Syracuse's] claim.

Report and Recommendation at 5. Addressing the calculation of depreciation, the District Court noted that Syracuse conced[ed] in its brief that Northbrook may have had a reasonable basis for its depreciation calculation." Id. at 6. The District Court then stated:

> [A]fter the completion of discovery, Syracuse does not even present a single argument that the depreciation calculation of $4,288.16 as applied against a total claim of $51,718.67 was unreasonable. In the absence of a colorable argument of unreasonableness in the calculation, evidence concerning the method of calculation of depreciation would not be relevant and admissible at trial to support an inference of a combination of factors that added together comprise bad faith.

Id. at 7.

The District Court's conclusion with respect to that portion of the bad faith claim based on lost profits was similar:

> [Syracuse] again does not present any factual interpretation or theory supporting a claim of bad faith or unreasonableness in connection with the handling of the lost profits portion . . . of the claim. . . .

Id. at 9.

We have reviewed the record in this matter and are convinced that the grant of partial summary judgment on the depreciation and lost profits elements of the bad faith claim was appropriate. We agree with the District Court that where Syracuse failed to establish even an inference of bad faith in calculating depreciation or lost profits, evidence relating to those calculations was irrelevant to the overall claim of bad faith.[2]

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[2]On appeal, Syracuse's sole argument regarding the grant of summary judgment as to the calculation of depreciation is one never advanced in the District Court. Syracuse contends that under Pennsylvania law depreciation may not be deducted where there has been a partial loss that does not exceed the depreciated value of the whole property. Assuming, arguendo, that this is a correct statement of the law applicable to the facts of this case, Syracuse still has failed to meet its burden of proof on the depreciation element of its claim. Syracuse was required to show that Northbrook did not have a reasonable basis under the law for calculating deprecation and that Northbrook "knew or recklessly disregarded its lack of reasonable basis" in making that calculation. Terletsky v. Prudential Property and Casualty Ins. Co., 437 Pa. Super. 108, 649 A.2d 680, 688 (1994). Syracuse does not point to anything in the record that would support even an inference that Northbrook lacked a reasonable basis for its calculation. In fact, as we have noted, Syracuse, in its brief filed in opposition to Northbrook's motion for summary judgment, clarified that Northbrook was not guilty of bad faith or reckless conduct for asserting that it had a legal right to subtract depreciation.

B.

Sanctions imposed for untimely filing of expert's report.

Syracuse's remaining challenge to the grant of partial summary judgment in favor of Northbrook focuses on that portion of the order striking the report of Syracuse's expert as untimely and directing that Syracuse reimburse Northbrook for costs and attorney's fees associated with the motion to strike the report.

A District Court's ruling excluding evidence because of counsel's failure to adhere to a pretrial order will not be disturbed on appeal absent a clear abuse of discretion. DeLaval Turbine, Inc. v. West India Indus. Inc., 502 F.2d 259 (3d Cir. 1974). In determining whether there has been an abuse of discretion, we consider four factors: "(1) the prejudice or surprise in fact to the party against whom the excluded witness would have testified; (2) the ability of that party to cure the prejudice; (3) the extent to which waiver of the rule against calling unlisted witnesses would disrupt the orderly and efficient trial of the case or of other cases in the court; and (4) bad faith or wilfulness in failing to comply with the court's order." Meyers v. Pennypack Woods Home Ownership Assn., 559 F.2d 894, 904-05 (3d Cir. 1977).

The record in this matter establishes that the District Court was aware of the Meyers factors and referenced them in its decision to exclude the testimony of Northbrook's expert:

> Although we did not require [Northbrook] to establish that admitting the expert's proposed testimony would cause prejudice, nor whether such prejudice could be cured, we did determine that [Syracuse's] behavior was in disregard of the rule of civil procedure and the case management plan for this case. . . . There was no excuse for Syracuse awaiting the report by Northbrook's expert before presenting its own witness. To allow [Syracuse] to introduce opinion evidence which could have (and should have) been produced initially would have affected the orderly prosecution of the case. Following [Syracuse's] disregard of the discovery deadline (through a request for production of documents) we conclude that the sanction imposed was a valid exercise of our authority under Fed. R. Civ. P. 37.

Syracuse Exploration Co. v. Northbrook Prop. & Cas. Ins., Co., No. 1:CV-97-1405, memorandum at 5-6, (M.D. Pa. Sept. 28, 1999). We do not find reason in the record to disagree with the District Court's finding that Syracuse was responsible for the position in which it found itself with regard to its expert's report: The report was filed nearly four months after the date established by the case management plan and "there was no excuse" for this late filing. It is also clear that this late filing was not Syracuse's first infraction of the case management plan and that consideration of the report at the time of its proffer would have had a significant impact on "orderly prosecution of the case." In these circumstances, the District Court did not require that Northbrook make a showing of prejudice. As the District Court explained, the other Meyers factors so heavily weighed in favor of striking the expert's report that the showing of prejudice "was not required." On the facts of this case, we will not disturb the District Court's ruling. No one of the

Meyers factors is dispositive and we do not find that the Court's application of those factors supports Syracuse's argument that the sanctions imposed were based on a clear abuse of discretion.

III.

We address next Syracuse's contention that the District Court erred in failing to grant its motion for a new trial. Our decision in Bhaya v. Westinghouse Electric Corp., 922 F.2d 184 (3d Cir. 1990) establishes that when we review a District Court's decision to grant or deny a motion for a new trial, we must accord substantial deference to the decision of the District Court which "saw and heard the witnesses and has the feel of the case which no appellate transcript can impart." Id. at 187 (quoting Cone v. West Virginia Pulp & Paper Co., 330 U.S. 212, 216 (1947). With this standard in mind, we turn to the grounds supporting Syracuse's motion for a new trial.

A.

Allegations of error related to evidentiary issues.

Three of the allegations of error made by Syracuse in connection with the District Court's denial of its motion for a new trial relate to the admission or exclusion of evidence. Our standard of review with respect to evidentiary issues is especially narrow. A finding that a new trial is required "may not be predicated upon a ruling which admits

or excludes evidence unless a substantial right of the party is affected." Glass v. Philadelphia Elec. Co., 34 F.3d 188, 191 (3d Cir. 1994) (quoting Linkstrom v. Golden T. Farms, 883 F.2d 269 (3d Cir. 1989)). Nonconstitutional evidentiary error in a civil suit warrants reversal only where it is highly probable that the error affected the outcome of the case. Glass, 34 F.3d at 91.

Syracuse alleges that it was entitled to a new trial based on the District Court's: (1) admission of the testimony of Northbrook's expert witness; and (2) exclusion of evidence relating to Northbrook's non-renewal of Syracuse's insurance policy and testimony concerning Syracuse's financial status. We address these allegations of evidentiary error seriatim, considering first the testimony of Northbrook's expert witness. Syracuse contends that this expert, an attorney, was permitted to testify, over objection, "to legal issues which are reserved for the court." Northbrook's expert was called to testify in this bad faith action based on his familiarity with acceptable claims-handling standards and practices in the insurance industry. We have reviewed the transcript of the expert testimony challenged by Northbrook and are convinced that the District Court was careful to guard against allowing the expert to testify to matters reserved to the Court. We agree with the substance of Northbrook's characterization of the expert testimony:

> Noticeably absent from [the expert] testimony is any discussion of (or even reference to) the Pennsylvania bad faith statute, the legal standards governing the determination of liability under the statute, a definition of "bad faith," or any other matter exclusively within the province of the district

> court. Indeed, on the one occasion when questioning by Northbrook's counsel arguably invited an opinion regarding the law of bad faith, the district court sustained the objection of Syracuse's counsel and appropriately limited the scope of Northbrook's counsel's inquiry.

We do not find any abuse of discretion in the District Court's admission of this evidence.

Our conclusion is similar with respect to the other evidentiary rulings challenged by Syracuse in its motion for a new trial. Syracuse contends that the District Court erred in excluding evidence of Northbrook's failure to renew Syracuse's insurance policy and in precluding Syracuse's owner from testifying about the financial status of the company. We evaluate exclusion of these items of evidence in the context of what was at issue. As the District Court observed, "The only question at trial was whether Syracuse proved by clear and convincing evidence that Northbrook's handling of Syracuse's claim was done in bad faith." Memorandum (September 28, 1999) at 2.

The District Court concluded first that the excluded evidence relating to non-renewal of the insurance policy was not relevant in determining whether Syracuse had operated in bad faith. The court also concluded that Syracuse's argument that the non-renewal was itself evidence of bad faith was "not supported by decisions interpreting the Pennsylvania bad faith statute." Id. at 4. We agree with both of these conclusions and, accordingly, find that the District Court's exclusion of evidence relating to non-renewal was consistent with the sound exercise of judicial discretion.

The District Court's decision to exclude evidence bearing on Syracuse's financial status was also consistent with the sound exercise of judicial discretion. We agree with the District Court's analysis of the evidence:

> [Syracuse] never offered to show that [Northbrook] knew of [Syracuse's] financial status. Because an insured's financial condition, standing alone, cannot establish bad faith on the part of the insurer, there was no error in excluding this evidence.

Id. at 7.

B.

The charge to and questions from the jury

Syracuse next argues that it is entitled to a new trial based on the District Court's: (1) decision not to hold a charge conference; (2) failure to rule on the parties' proposed jury instructions prior to closing argument; (3) failure to deliver certain instructions requested by Syracuse, particularly those relating to the Unfair Insurance Practices Act; and (4) formulation of answers to questions posed by the jury during the course of deliberation.

Syracuse failed to bring any of these alleged errors to the attention of the District Court. As a result, our review is limited by the plain error standard. "[W]e will reverse only if the trial court committed plain error that was fundamental and highly prejudicial . . . ." Alexander v. Riga, ___ F.3d ___, 2000 WL 295288 *4 (3d Cir. 2000).

Applying this standard to the allegations of error raised by Syracuse, we do not find any ground upon which to reverse. A charging conference is not required by the governing rule, Fed. R. Civ. P. 51. Syracuse did not object to the District Court's failure to rule on the parties' request for jury instructions and does not explain here how it was prejudiced by this failure. This would, indeed, be a difficult argument to make given that Syracuse failed to object to the instructions given at any point prior to the jury's retiring to deliberate, despite having been invited by the court to do so.

Likewise, we do not find error, plain or otherwise, in the District Court's charge to the jury. We agree with Northbrook that the instructions given fairly and adequately identified the issues in the case. The District Court thoroughly explained its decision not to instruct the jury regarding the Unfair Insurance Practices Act (UIPA):

> The UIPA is concerned with improper conduct that occurs so frequently as to rise to the level of a "business practice." The bad faith statute, on the other hand, is concerned only with an insurer's actions in a specific case. . . . Instructing the jury on the UIPA might lead to confusion. We believe the better approach is to permit the instruction of evidence showing non-compliance with the UIPA, as Syracuse did here, but to allow the jury to decide whether this is evidence of bad faith as that term is defined in the law.

Memorandum (September 28, 199) at 11.

We have reviewed, too, the District Court's answers to questions posed by the jury during the course of deliberation. The record establishes that the District Court discussed its proposed answers to these queries with counsel for both parties and that

Syracuse did not register any objection. We find nothing in the District Court's communication with the jury to suggest that Syracuse suffered any prejudice at all, let alone the degree of prejudice necessary to support a finding of plain error.

We are convinced that the allegations of error in the District Court's admission and exclusion of evidence lack merit and do not warrant the grant of a new trial.

C.

Alleged misconduct on the part of counsel for Northbrook

Syracuse contends that the District Court erred in denying its motion for a new trial where counsel for Northbrook engaged in unprofessional conduct by instructing a witness not to bring an allegedly relevant file to court. We have reviewed the record as it relates to this claim and are convinced that the District Court's refusal to grant a new trial based on the alleged misconduct was consistent with the sound exercise of judicial discretion. The District Court's analysis of this issue was sound and we adopt it here:

> In its initial disclosures in December 1997, [Northbrook] informed [Syracuse] that [the witness] was involved in handling [Syracuse's] claim. [Northbrook] also indicated in its pretrial memorandum that [the witness] would testify at trial. Because [the witness] is not an employee of [Northbrook], his files were not in possession or control of [Northbrook] and they were not produced in response to a request for documents. However, [Syracuse] had ample opportunity to subpoena the . . . files. The failure to do so

> cannot be blamed on [Northbrook] nor provide a basis for a new trial. . . . Furthermore, [Syracuse] has not shown that the failure to produce [the] . . . files was prejudicial.

Memorandum (September 28, 1999) at 9 (citations omitted).

IV.

Because Syracuse's allegations of error with respect to the grant of Northbrook's motion for partial summary judgment and the denial of Syracuse's motion for a new trial lack merit, we will affirm the orders of the District Court.

TO THE CLERK:

Please file the foregoing opinion.

/s/ Carol L. Mansmann
Circuit Judge

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 99-3811

SYRACUSE EXPLORATION COMPANY,
Appellant

v.

NORTHBROOK PROPERTY & CASUALTY
INSURANCE COMPANY

Appeal from the United States District Court
for the Middle District of Pennsylvania
(D.C. Civ. No. 97-cv-01405)
District Judge: Honorable William W. Caldwell

Before: SLOVITER and MANSMANN, Circuit Judges
and WARD,* District Judge.

JUDGMENT

This cause came to be considered on the record from the United States District Court for the Middle District of Pennsylvania and was submitted under Third Circuit LAR 34.1(a) on May 23, 2000.

*Honorable Robert J. Ward, of the United States District Court for the Southern District of New York, sitting by designation.

On consideration whereof, it is now here ordered and adjudged by this court that the judgments of the District Court entered on December 31, 1998 and September 29, 1999, be and the same are hereby affirmed.

Costs taxed against the appellant.

ATTEST:

Acting Clerk

Date: May 26, 2000

C

SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
WASHINGTON, D. C. 20543

November 27, 2000

Mr. Richard C. Angino
4503 North Front Street
Harrisburg, PA 17110

Re: Syracuse Exploration Company
v. Northbrook Property and Casualty Insurance Company
No. 00-309

Dear Mr. Angino:

The Court today entered the following order in the above entitled case:

The petition for a writ of certiorari is denied.

Sincerely,

William K. Suter

William K. Suter, Clerk

H

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

SYRACUSE EXPLORATION COMPANY,	:	CIVIL ACTION LAW
Plaintiff	:	JUDGE CALDWELL
v.	:	NO. 1:CV-97-1405
NORTHBROOK PROPERTY & CASUALTY INSURANCE CO.,	:	MAGISTRATE JUDGE SMYSER
Defendant	:	JURY TRIAL DEMANDED

PLAINTIFF'S POINTS FOR CHARGE

AND NOW comes the Plaintiffs, pursuant to Middle District Rule 51, and submits the enclosed Points for Charge.

Respectfully submitted,

ANGINO & ROVNER, P.C.

Richard C. Angino, Esquire
I.D. No. 07140
James DeCinti, Esquire
I.D. No. 77421
4503 North Front Street
Harrisburg, PA 17110
Counsel for Plaintiff

Dated: 6/4/99

151111/SC

Plaintiff's Point for Charge No. 1

Under Pennsylvania law, an insurer has an obligation to exercise good faith in its handling of a claim with its insured. An insurer, such as Northbrook, can be held liable if it does not exercise good faith in its handling of a claim with its insured. Cowden v. Aetna Casualty and Surety, 389 Pa. 459, 468, 134 A.2d 223, 227 (1957).

_____ Affirmed _____ Denied

Plaintiff's Point for Charge No. 2

There is a fiduciary duty between the insurer, Northbrook, and the insured, Syracuse. Northbrook must "accord the interest of its insured Syracuse the same faithful consideration it gives its own interest." Polselli v. Nationwide Mut. Fire Ins. Co., 23 F.3d 747, 752 (3d Cir. 1994), quoting, Cowden v. Aetna Casualty. and Surety Co., 389 Pa. 459, 134 A.2d 223, 228 (1957). Thus, Northbrook must act with the "utmost good faith" towards its insured. Fedas v. Insurance Company of Pa., 300 Pa. 555, 558, 151 A. 285, 286 (1930); Romano v. Nationwide Mut. Fire Ins. Co., 435 Pa. Super. 545, 646 A.2d 1228, 1231 (1994); see, also, Dercoli v. Pennsylvania National Mut. Ins. Co., 520 Pa. 471, 554 A.2d 906 (1989); Cowden v. Aetna Casualty and Surety Co., 389 Pa. 459, 134 A.2d 223 (1957).

_____ Affirmed _____ Denied

Plaintiff's Point for Charge No. 3

Plaintiff Syracuse has alleged that the Defendant Northbrook acted in bad faith by failing to respond promptly to its claim, by failing to engage an experienced appraiser, by delaying in making a decision authorizing repairs, and by other actions that resulted in the delay in repairing Syracuse's drill rig.

To recover under a claim for bad faith, Syracuse must prove that Northbrook intentionally or recklessly disregarded its responsibility of good faith to its insured, Syracuse and/or intentionally or recklessly delayed in authorizing repairs to Syracuse's drill rig. See, Polselli v. Nationwide Mut. Fire Ins. Co., 23 F.3d 747 (3d Cir. 1994); Terletsky v. Prudential Property and Casualty Ins. Co., 437 Pa. Super. 108, 649 A.2d 680 (1994); Klinger v. State Farm Mut. Auto. Ins. Co., 115 F.3d 230 (3d Cir. 1997).

_____ Affirmed _____ Denied

Plaintiff's Point for Charge No. 4

> Implicit in the duty of good faith and fair dealing is the insurer's obligation to be fair and honest with its insured and to give equal consideration to the insured's interests."

Appleman, *Insurance Law and Practice*, §8878 (1994 pocket part, at 12). Further,

> The duty of good faith and fair dealing that an insurer owes an insured obligates the insured to refrain from (1) engaging in unfounded refusals to pay policy proceeds, (2) causing unfounded delay in making payment, (3) deceiving the insured, and (4) exercising any unfair advantage to pressure an insured into settlement of the insurance claim.

Appleman, *Insurance Law and Practice*, §8878 (1994 pocket part, at 12).

_____ Affirmed _____ Denied

Plaintiff's Point for Charge No. 5

The Pennsylvania Unfair Insurance Practices Act defines unfair methods of competition and unfair or deceptive acts or practices in the insurance business. The Pennsylvania Unfair Insurance Practices Act provides guidance in defining bad faith. See, MacFarland v. United States Fidelity and Guarantee Co., 818 F.Supp. 108, 110 (E.D. Pa. 1993); Coyne v. Allstate Insurance Co., 771 F.Supp. 673, 678 (E.D. Pa. 1991); Klinger v. State Farm Mut. Auto. Ins. Co., 115 F.3d 230 (3d Cir. 1997); Polselli v. Nationwide Mut. Fire Ins. Co., 23 F.3d 747, 751 (3d Cir. 1994); and Romano v. Nationwide Mut. Fire Ins. Co., 435 Pa. Super. 545, 646 A.2d 1228-1332 (1994). The following insurance practices are prohibited:

> (i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.
>
> (ii) Failing to acknowledge and/or fail to act promptly upon written or oral communications with respect to claims arising under insurance policies.
>
> (iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.
>
> (iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.
>
> * * *
>
> (vi) Failing to attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.

(vii) Compelling persons to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts due and ultimately recovered in actions brought by such persons.

40 P.S. §1171.5. If you find that Northbrook intentionally or recklessly disregarded any of the prohibited provisions of the insurance law, you may find it liable for failing to fulfill its duty of good faith to its insured.

_____ Affirmed _____ Denied

Plaintiff's Point for Charge No. 6

Our Insurance Department publishes minimum standard regulations to control the insurance companies selling insurance coverage in Pennsylvania. The regulations provide:

> **§ 146.5. Failure to acknowledge pertinent communications.**
>
> (a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.
>
> * * *
>
> **§ 146.6. Standards for prompt investigation of claims.**
>
> Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.
>
> **§ 146.7. Standards for prompt, fair and equitable settlements applicable to insurers.**
>
> (a) Acceptance or denial of a claim shall comply with the following:
>
> (1) Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny

> a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.
>
> (b) If a claim is denied for reasons other than those described in subsection (a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.
>
> (c) The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination:
>
> (1) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected.

31 Pa. Code §§146, et seq. If you find that Defendant Northbrook violated any of the Insurance Department regulations, you may find it liable for failing in its responsibility of good faith to its insured.

_____ Affirmed _____ Denied

Plaintiff's Point for Charge No. 7

While "mere negligence on the part of the insurer is insufficient to constitute bad faith, recklessness can support a finding of bad faith." "[A]n insured [such as Syracuse], need not show both ill-will and recklessness. Rather, the degree of recklessness required to succeed on such a claim in effect [can rise] to the level of 'improper purpose'." Polselli v. Nationwide Mut. Fire Ins. Co., 23 F.3d 747, 751 (3d Cir. 1994); Judge Caldwell's August 21, 1994, Memorandum, at p. 14. in Klinger v. State Farm; and Klinger v. State Farm Mut. Auto. Ins. Co., 115 F.3d 230 (3d Cir. 1997)

_____ Affirmed _____ Denied

Plaintiff's Point for Charge No. 8

Proof that Northbrook acted with sincerity is not the equivalent of proof of good faith. The good faith standard requires more than proof of sincerity. In fact, bad faith can be evidenced by reckless indifference to the rights of the insured and exists when an insurance company breaches its duty of good faith and fair dealing to the insureds. These duties of good faith and fair dealing require an insurance company, such as Northbrook, to promptly handle and pay insurance claims and not to unnecessarily delay in making decisions as to repair or replacement. Shearer v. Reed, 286 Pa. Super. 188, 193-194, 428 A.2d 635, 638 (1981); see, also, Bracciale v. Nationwide Mut. Fire Ins. , 1993 LEXIS 11606 (E.D.Pa. 1993).

_____ Affirmed _____ Denied

Plaintiff's Point for Charge No. 9

Bad faith can be found where the insurer has found to have put its own interests before the insured's. Polselli v. Nationwide Mut. Fire Ins. Co., 23 F.3d 747, 752 (3d Cir. 1994); Puritan Ins. Co. v. Canadian Universal Ins. Co. Ltd., 775 F.2d 76, 79 (3d Cir. 1985), citing, U.S. Fire Ins. Co. v. Royal Ins. Co., 759 F.2d 306, 311 (3d Cir. 1985).

_____ Affirmed _____ Denied

Plaintiff's Point for Charge No. 10

Plaintiff Syracuse must prove Defendant Northbrook's "bad faith" by evidence that is "clear, direct, weighty, and convincing." Polselli v. Nationwide Mut. Fire Ins. Co., 23 F.3d 747 (3d Cir. 1994) and 126 F.3d 524 (3d Cir. 1997).

_____ Affirmed _____ Denied

Plaintiff's Point for Charge No. 11

If you determine that Northbrook acted in bad faith, then you may award the Plaintiff punitive damages. The purpose of punitive damages is to punish Northbrook for its outrageous conduct and to deter it and others from like conduct in the future. Kirkbride v. Lisbon Contractors, Inc., 521 Pa. 97, 555 A.2d 800, 803 (1989).

_____ Affirmed _____ Denied

Plaintiff's Point for Charge No. 12

If you decide that the Plaintiff is entitled to an award of punitive damages, the amount of such damages must be fixed by you. In doing so, you may consider any or all of the following factors:

1. The character of Northbrook's conduct;
2. The nature and extent of the harm to Syracuse caused by Northbrook and Northbrook's trouble and expense in seeking to protect their interest in legal proceedings and in the suit; and
3. The wealth of Northbrook insofar as it is relevant in fixing an amount which will punish it, and deter it and others from like conduct in the future.

The amount of punitive damages awarded must not be the result of passion or prejudice against Northbrook. The sole purpose of punitive damages is to punish Northbrook's outrageous or reckless conduct, and to deter Northbrook and others from the commission of like acts. Kirkbride v. Lisbon Contractors, Inc., 521 Pa. 97, 555 A.2d 800 (1989); Restatement (Second) of Torts §908 (1979).

_____ Affirmed _____ Denied

CERTIFICATE OF SERVICE

I, Richard C. Angino, hereby certify that a true and correct copy of the foregoing **Plaintiff's Points for Charge** has been served in the following manner upon the following:

VIA HAND DELIVERY ON JUNE 4, 1999

Robert E. Kelly, Jr., Esquire
Duane Morris & Heckscher LLP
305 North Front Street
P. O. Box 1003
Harrisburg, PA 17108-1003

VIA HAND DELIVERY ON JUNE 7, 1999

Anthony R. Zelle, Esquire
Robinson & Cole
1 Boston Place
Boston, MA 02108

Richard C. Angino

Dated: 6/4/99

CERTIFICATE OF SERVICE

I, Richard C. Angino, Esquire, hereby certify that a true and correct copy of the foregoing **PLAINTIFF'S BRIEF CONTRA DEFENDANTS' MOTION FOR SUMMARY JUDGMENT** was served by United States first-class mail, postage prepaid, upon the following:

E. Thomas Henefer, Esquire
Stevens & Lee
111 North Sixth Street
P. O. Box 679
Reading, PA 19603-0679
Counsel for Paul Revere Life Insurance Company and New York Life Insurance Company

Richard C. Angino

Dated: 8/26/02